Health Care Reimbursement Trends: A Driver of Consolidation and Affiliation

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Introduction and Background

Anyone involved in the health care industry or who watches the news is aware of the plethora of consolidations in recent years. What are the driving forces behind the uptick in such activity? The industry is responding to a variety of pressures coming from many angles. Medicare, the largest payer for health care services in the United States, is under increasing budgetary pressure to reduce its cost to taxpayers while incentivizing value and quality care, not just volume of services. Commercial payers continue to fight growing business and consumer dissatisfaction with rising insurance premiums and a growing financial burden on patients. Employers are striving to find more cost-effective avenues for providing health coverage to their employees and are exploring creative alternatives to traditional commercial payers. Patients are becoming more educated—and vocal—and are demanding greater value and continuity in their interactions with the health care delivery system. The United States spends more per capita and as a percentage of GDP on health care than any other developed country,¹ so while there are differences in opinion regarding how to fix the system, most believe that the current landscape is not sustainable.

As these pressures build, both traditional health care entities as well as new players are entering the fray to vie for a piece of the $3.6 trillion health care market.² In 2019, ninety-two hospital merger transactions were announced, which is consistent with the level of merger activity in the prior year.³ As hospital “mega-mergers” continue, multiple types of partnerships across a diverse mix of entities are being formed. Health systems, commercial payers, physician groups (increasingly private equity backed), and digital health companies are forming alliances as they seek ways to improve upon the patient experience and the overall value of health care services.⁴

Consolidation trends are expected to continue as the health care industry and investors respond to the firestorm of increasing pressures. Private equity firms are sitting on $1.5 trillion in “dry powder,” and health care has proven to be an attractive landing place for available capital.⁵ Additionally, private equity firms continue to gamble that such scale will allow physician practice management platforms to improve infrastructure, technology, clinician recruitment, and clinical support,⁶ ultimately leading to improved profitability. Other players, such as rural hospitals and independent physician groups, are simply looking for ways to survive amidst tightening reimbursement, increased regulatory requirements, and rising costs.

Changes in reimbursement, regulatory complexity, competition, and the availability of capital have all contributed to an environment that rewards size and scale at every segment of the health care continuum. The lines between for-profit and not-for-profit, provider and payer, physician group and hospital continue to blur as these players pursue various strategies for growth and improvement of health care delivery across the spectrum.

Health care reimbursement, or the manner in which health care services are funded by the government and commercial insurers (and ultimately patients and taxpayers), is a complex world of payment formulas, fee schedules, policies, and procedures that continues to evolve as insurers and policy makers look for ways to incentivize healthy outcomes and control costs. Understanding current and anticipated changes to reimbursement is necessary for anyone facilitating or evaluating transactions, as revenue critically impacts the ability of a provider to meet its mission or provide a return to its investors. Furthermore, reimbursement changes will not only have a significant financial impact but will also drive changes in provider behavior and operational structures that should be considered in any health care organization’s long-term strategy.

This article will focus on current and anticipated changes to health care reimbursement and how such changes influence the churn within the health care industry. Significant changes are occurring across the acute care, physician, and post-acute care spectrum, and these transformations are in turn driving organizations to grow in scale or find new partners in order to be prepared for a post-fee-for-service landscape.

The first section of this article will provide an overview of reimbursement trends and expectations across various health care settings, and the second half will examine keys to success in affiliation transactions as well as different strategies for health care consolidation and affiliation.
Reimbursement Trends

Population Health

Population health is a term that gained wide usage after the passage of the Patient Protection and Affordable Care Act (ACA) in 2010. The term is defined as “the health outcomes of a group of individuals, including the distribution of such outcomes within the group,” and it is a guiding principle of many health care reimbursement policies and changes that have occurred in recent years. More broadly, population health fits within the “Triple Aim” of health care reform: improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations.\(^9\)

Population health changes the reimbursement paradigm from the historical “fee-for-service” or “paying for volume” model to reimbursement based on health outcomes. Outcome-based reimbursement and reimbursement that incentivizes cost reduction is referred to as value-based care. There are numerous programs in place, led largely by the federal government, that are pushing providers towards value-based care models. Private payers have been slower to adopt value-based arrangements for their commercial populations, but are expected to eventually catch up to the government based on the industry adage that, “as Medicare goes, so goes the private market.”\(^8\) This push towards value-based care is happening across the care continuum with major initiatives underway that affect acute care facilities, physicians, and post-acute care providers.

Acute Care

Hospitals and other acute care providers are seeing a number of programs intended to shift these entities away from fee-for-service reimbursement. These programs fall under the primary categories of Value-Based Programs, Bundled Payments, and Shared Savings Plans.

The term Value Based Programs specifically refers to several programs run by the Centers for Medicare and Medicaid Services (CMS) that reward health care providers with incentive payments for the quality of care they provide to Medicare beneficiaries.\(^10\) According to CMS, these programs are part of its larger strategy to reform how health care services are delivered and reimbursed. These programs support the “Triple Aim” of better care for individuals, better overall health for populations, and lower cost.\(^11\)

Bundled Payments, which describe a single payment for both hospital and physician services related to specific episodes of care, have been discussed in various forms since the late 1980s. This idea gained traction beginning in 2013 with CMS’s introduction of the Bundled Payments for Care Improvement Initiative (BPCI). The purpose of bundling is to encourage care coordination and align incentives for all providers—hospitals, physicians, post-acute care providers, and other practitioners.\(^12\) There are currently over 900 providers across the U.S. participating in BPCI demonstration projects that cover 35 different episodes of care.\(^13\) If these projects prove to be effective in improving outcomes and reducing costs, this form of reimbursement is expected to expand in coming years.

The concept of Shared Savings was introduced with Accountable Care Organizations (ACOs) that were established with the passage of the ACA in 2010. ACO members receive a portion of any cost savings associated with treating a patient who is a part of the ACO. When introduced in 2010 under the Medicare Shared Savings Program (MSSP), providers were subject to “upside risk” only, meaning they would receive a percentage of the savings if costs were below a pre-determined baseline, but would not be penalized if costs exceeded such baseline. Higher risk “two-sided” models involving both upside and downside risk are now a part of MSSP also and were expanded by CMS with Next Generation ACOs (NexGen) and now Direct Contracting (DC), which was introduced in April 2019.\(^14\) In these higher risk models, participants share in the losses if treatment costs are above a calculated threshold. In some DC models, participants participate in 100% of both shared savings and shared losses.\(^15\)

All these models are anticipated to grow in popularity over the next decade\(^16\) as the pressures associated with the “Triple Aim” increase. In order to expedite movement towards value-based reimbursement, it is anticipated that many of the voluntary alternative payment programs such as BPCI could become mandatory.\(^17\)

Physician Services

Similar to the shift experienced in the acute care spectrum, physicians also feel the pressure to focus on quality and patient outcomes in order to achieve optimal reimbursement levels from Medicare and other payers to allow their practices to remain viable.

As a part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), a Quality Payment Program was created to streamline multiple quality programs under the Merit Based Incentive Payments System (MIPS) and give bonus payments to providers for participation in eligible Alternative Payment Models (APMs).\(^18\) MIPS was created to link payments to quality and cost-efficient care, drive improvement in care processes and health outcomes, increase the use of health information, reduce the cost of care, and update and consolidate previous programs. Participants in MIPS receive a score related to four performance categories (quality, promoting interoperability, improvement activities, and cost), and the aggregate score determines a payment adjustment for Medicare reimbursement.\(^19\) An APM can apply to a specific clinical condition, a care episode, or a population, and is defined as “a payment approach that gives added incentive payments to provide high quality and cost-efficient care.”\(^20\)

Historically, value-based payment model options for primary care have been limited. However, an emphasis on primary care and a coordinated effort between public and private payers has resulted in the introduction of primary care value-based programs. Such programs include Comprehensive Care Plus (CPC+), a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. CPC+ is a unique public/private partnership, which currently has 2,851 participants in 18 regions and is centered on five key functions: access and continuity, care management, comprehensiveness and coordination, patient and care giver engagement, and planned care and population health.\(^21\)

Primary Care First (PCF) is another new program, launching in 2021. PCF will build upon the ideas of CPC+, creating a seamless continuum of care. This program provides two payment models that test whether delivery of advanced primary care can reduce the total cost of care. Under PCF, advanced primary care practices ready to assume financial risk will experience reduced administrative burdens and re-
ceive performance-based payments. A second payment model under Medicare, the Patient-Driven Payment Model (PDPM) for Skilled Nursing Facilities (SNFs), effective as of October 1, 2019. This program is designed to incentivize treatment of the whole patient and focuses care on the patient’s condition by adjusting Medicare payments based on each aspect of the patient's care and specific needs. Under this program, the amount of Medicare spending on therapy services is expected to decrease dramatically, while dollars are shifted to more medically complex cases (e.g., congestive heart failure). This initiative is expected to be budget-neutral in totality. This shift to value-based reimbursement will benefit those who provide care to the most complex patients, while challenging those who have historically focused primarily on the volume of services provided.

Though it was not Medicare’s intention, providers should expect (and have already found) that the reporting requirements and documentation of patient assessments under this model are more rigorous and require additional coordination of care with acute care providers than previous reimbursement models.

**Price Transparency**

While reimbursement changes related to population health attempt to influence how health care providers deliver care, in November 2019 the Trump administration issued rules aiming to influence patients and other consumers of health care by providing them more information about rates paid by insurers to hospitals. It is theorized by policy makers that patients, armed with this information, will be enabled to understand their anticipated out-of-pocket costs and "shop around" for health care services. The stated purpose of these rules is to promote competition among hospitals and insurers to drive down health care spending. These rules are slated to go into effect in January 2021 and will require hospitals to post in an electronic manner information regarding the hospital’s negotiated prices with insurers for certain “shoppable” services, which include a variety of common procedures or episodes of care.

The rules face a strong legal challenge from both hospitals and insurers, and it is unlikely these rules will go into effect in their current form. A similar rule requiring pharmaceutical companies to disclose list prices for drugs in television ads was recently overturned by a judge who opined that the administration overstepped its regulatory authority. Regardless of the current legal challenges, it is unlikely that the push towards transparency and increased information for patients will go away anytime soon as patients, employers, the government, and the general public push for changes to the status-quo.

**Consolidations and Affiliations: Keys to Success**

As reimbursement dynamics create pressure and opportunities for consolidation and affiliation within the health care industry, it is important that the goals for any contemplated affiliation strategy align with drivers of success under evolving payment models. These keys for success fall under three primary categories: Healthcare Delivery, Technology and Data Analytics, and Operational Efficiency.

**Health Care Delivery**

Health care delivery impacts the patient experience and health outcomes and is the primary purpose of any health care enterprise. The purpose of population health reimbursement models is to improve health care delivery and efficiency by incentivizing coordination among all the various providers of health care services. Care coordination can be defined as “the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services.”

If payment for services is based on an episodic global payment encompassing hospitals, physicians, and ancillary providers, or one that measures the quality of care provided, then the delivery of health care needs to become highly coordinated with all parties communicat-

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**KEYS TO SUCCESS**

To successfully navigate the affiliation landscape, we've identified three critical areas organizations need to focus on when considering their strategic options:

- Healthcare Delivery
- Technology and Data Analytics
- Operational Efficiency
ing effectively with one another. This requires clear communication protocols and systems as well as highly qualified and well-trained clinicians and support staff.

Proposed updates to the Anti-Kickback Statute and Stark law regulations, which were published by the Department of Health and Human Services’ (HHS) Office of Inspector General (OIG) and CMS, respectively, in October 2019, attempt to remove regulatory barriers to the adoption of value-based arrangements and promote care coordination among providers. These proposed updates contain three new safe harbors that would provide protection for providers participating in value-based care arrangements. These proposed safe harbors are intended to provide protection to Value-Based Enterprises whose purpose is to “foster better care at lower cost through improved care coordination with patients.” The safe harbors cover the following types of arrangements:

- Care coordination arrangements to improve quality, health outcomes, and efficiency (1001.952(ee));
- Value-based arrangements with substantial downside financial risk (1001.952(ff)); and
- Value-based arrangements with full financial risk (1001.952(gg)).

The updates, which are expected to be issued in final form in 2020, are a clear indication of the government’s intent to steer the industry towards value-based models in connection with the broad goals of improving patient outcomes and reducing the overall cost of care.

Technology and Data Analytics

Technology will play a significant role in the success of any affiliation transaction. Electronic health records and related systems must be able to communicate and integrate with one another, particularly as providers work to gather and submit data required for value-based reimbursement initiatives. Accounting systems, inventory systems, asset tracking systems, and many others need to work together or be merged as well. Technology must be deployed in such a way to facilitate provider communication, patient tracking, and patient outcomes in a cost-effective manner.

A vital component of tracking patient outcomes and costs of care associated with such patients will be deploying deep data analytics to convert all the data generated by new technologies into meaningful information to enhance revenue, decrease cost, and improve outcomes. An affiliation that does not consider the role of data analytics will not be well-positioned for the upcoming changes to reimbursement. As one physician group executive stated at a recent industry conference, his group has a “focus on data collection in anticipation of value-based care.” It is widely understood that data collections and analytics will play a vital role if value-based care is to be successful at scale.

Technology and data analytics are two of the reasons non-traditional players such as Optum have entered the provider side of health care. As noted in a recent article, Optum Health is “wiring” together its network of recently acquired primary care practices, surgery centers, and urgent care clinics in order to provide physicians with advice based on Optum’s massive stores of data and analytics capabilities.

Operational Efficiency

Efficiently delivering health care services to patients in a constrained reimbursement environment will increase in importance over the coming years. As value-based reimbursement and price transparency increase, cost-shifting—which is the subsidization of unprofitable services or payers by profitable ones—will become more difficult. For example, in many markets, commercial payers in essence subsidize health care providers for losses incurred in providing services to Medicare and Medicaid patients, given that reimbursement by these government payers is often at or below the cost associated with providing care. However, this will become more difficult in an environment of increased market competition through price transparency combined with an emphasis on reimbursement tied to patient outcomes and cost reduction, regardless of payer. In addition, as two-sided risk payment models are introduced and providers are penalized financially for failing to provide care within predetermined cost benchmarks, operational efficiency must increase.

The goal of operational efficiency is a driver of affiliation strategies focused on increased size and scale. Participants strive to achieve economies of scale through consolidation of large fixed cost components such as electronic health record systems, revenue cycle operations, and administration. This is one of the primary reasons private equity has entered the health care arena. Their strategy hinges on significant improvements in operational efficiency that will enable the post-transaction profitability to greatly exceed the historical financial results of the entities, achieving a financial return to investors.

Consolidations and Affiliations: Different Models

As the consolidation trend continues, different models of consolidation and affiliation have taken shape. These models can range from loose affiliations to a full merger of two entities. Each potential structure should be considered within the context of the changing reimbursement environment and the keys to success noted above.

Clinical Affiliation

A Clinical Affiliation is an agreement for two or more entities to collaborate on an initiative or provide a specific service together. This may involve local, regional, or national partners. For example, the Mayo Clinic Health Care Network is a nationwide network in which hospitals and health systems enter into clinical affiliations with the Mayo Clinic to improve the quality and delivery of care in their regions by taking advantage of Mayo’s expertise and gaining access to various Mayo resources. Clinical affiliations also help align physicians, nurses, and other providers across the care continuum, which is important in the era of bundled payments and population health initiatives.

Regional Collaborative

A Regional Collaborative is a flexible structure for two or more entities to partner on specific initiatives and build the foundation for potential future integration. As the name suggests, these collaboratives usually involve independent entities in a common geographical area. An example of this type of model is the formation of Southwestern
Clincal Affiliation
Agreement to collaborate on an initiative or provide a specific service together.

Regional Collaborative
A flexible structure for partnering on specific initiatives and building the foundation for potential future integration.

Accountable Care Organization
An independent entity owned by constituent organizations and formed for the purpose of entering risk-based contracts.

Joint Venture
Short or long-term arrangement between unrelated entities to form and operate a common enterprise that pursues a new or existing activity or purpose.

Merger/Acquisition
The formal purchase of one organization’s assets by another, or the combination of two organizations’ assets into a single entity.

Private Equity
The involvement of private equity can exist at any aspect of the affiliation scale and is increasingly common. PE investors often focus on fragmented specialties to achieve efficiencies.

Hospitals can affiliate through several different avenues, each of which provide varying levels of independence versus support.

Accountable Care Organization
As discussed earlier, an ACO is an independent entity owned by constituent organizations and formed for the purpose of entering risk-based contracts. ACOs resulted from the ACA that was passed in 2010, and their purpose is to encourage continuity of care, reduce the cost of care, and create shared accountability. Providers in an ACO are jointly accountable for the health of their patients, receiving financial incentives to collaborate and reduce the cost of care by avoiding unnecessary or redundant tests and procedures.

Joint Venture
A Joint Venture can be a short-term or long-term arrangement between unrelated entities to form and operate a common enterprise that pursues a new or existing activity or purpose, while allowing for some level of involvement by all parties in the management or control of the activity. The entities that partner in a joint venture share both the risks and rewards of the activity. Many hospitals have entered joint ventures with operators who focus on specific ancillary services, such as imaging or ambulatory surgery.

Merger/Acquisition
At the far end of the affiliation scale is a Merger, which is the formal purchase of one organization’s assets by another, or the combination of two organizations’ assets into a single entity. One of the largest hospital mergers in recent history was the combination of Baylor Health Care System and Scott & White Healthcare to form Baylor Scott & White Health in 2013. The past two years have seen significant levels of hospital merger activity as entities pursue strategies of increasing their size and scale. However, these types of mergers should be carefully considered going forward, as “mega-mergers” are facing increased scrutiny. In January 2020, Federal Trade Commission (FTC) head Christine Wilson said that the agency would increase its scrutiny of the health care sector by challenging “every hospital merger.” This increased scrutiny of merger activity is occurring at the same time that hospitals are being asked to deliver on their promises of efficiencies and cost savings.

Private Equity
Private Equity transactions, in which owners of a health care service company sell a portion of their equity to a private equity investment firm, have become increasingly common in recent years. A 2019 article noted that “private equity investors are attracted to more consumer-friendly, alternative care-delivery models as the market shifts away from acute-care settings. Investors thus have been looking for ways to build scale in fragmented categories and geographies,” according to the report. Many of these private equity "roll-ups" hope to consolidate fragmented specialties to achieve efficiencies that will create value under new reimbursement models. Private equity investments have been made across all health care sectors, including acute care, physician medical groups, long-term care, and ancillary services (lab, MRI, Dialysis, etc.). In recent years, private equity has dramatically increased its investments in physician services and has focused on...
on physician specialties such as orthopedics, dermatology, urology, and gastroenterology. Primary care practices have become a new target as private equity investors seek to create large regional physician groups and gain efficiencies of scale and drive contract rates.37

Conclusion

Given the many pressures that exist for health care providers across the health care continuum, consolidation and alternative forms of affiliation are likely here to stay. In order for providers to remain competitive and serve their patients effectively in a climate of changing reimbursement, cost pressure, increased competition, collaboration, and accountability, it is essential that health care entities determine which, if any, affiliation and/or consolidation models work best to achieve their needs. When providers consider an affiliation strategy, it is critical to have knowledgeable advisors on their team who not only understand the macro drivers of consolidation, but also the micro-mechanics of reimbursement models that will transform the delivery of care in the future.

Amidst all the uncertainty in the health care industry, one thing is certain—health care organizations must adapt to the changes that are inevitably coming in order to be viable for the long-term. This involves first understanding the expected changes to reimbursement and creating care delivery models that will position the organization to be successful in that environment. This may involve affiliation with other players in the market to achieve desired size, scale, interoperability, quality outcomes, and operational efficiencies. In the end, health care providers all have the same goal: to provide high quality care to achieve healthy communities. Exactly how they get there is the question.

Endnotes

4. Ibid.
6. Ibid.
11. Ibid.
17. Ibid.
29. Ibid.
30. Quoted from industry panel of expert at private equity in healthcare conference, February 2020.
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