

The Source Roundup: December 2022 Edition

As the end of the year approaches, there's no better time to catch up and reflect upon new research and findings from the past year. The articles and reports in this month's Roundup examine the latest trends in consolidation including (1) the rise of cross-market hospital systems and (2) concentration in the insurance markets. We also highlight articles that explored (3) the current state and future of telehealth regulation and (4) quality impact for hospitals that switch to a value based payment model.

Consolidation and Competition

Although 2022 has seen a decrease in announced hospital merger and acquisition deals, researchers found that cross-market hospital systems have been on the rise. A recent *Health Affairs* paper jointly authored by economists and scholars from UC Berkeley's Petris Center and The Source on Healthcare Price and Competition examined [The Rise of Cross-Market Hospital Systems and Their Market Power in the US](#). According to authors Brent D. Fulton, Daniel R. Arnold, Jaime S. King, et al., between 2010 and 2019, there were 1,500 merged or acquired hospitals and 55% of them were in different commuting zones, signifying a cross-market hospital system. The authors noted that while cross-market hospital systems are likely to increase prices, none of the deals documented during the time period studied were challenged by antitrust enforcers because of the cross-market nature of the deals that involve different product and geographic markets. In 2020, California's attorney general became the first to intervene in a cross-market hospital

transaction for potential competitive impact. Looking forward, however, the researchers are cautious that there will be any similar action because of the difficulty in identifying an anti-competitive cross-market merger. For additional details and information on the research by The Source and Petris Center on cross-market systems, be sure to check out the [interactive key issue page](#) featured on The Source website.

Consolidation is also happening vertically with different types of providers merging together, such as hospitals acquiring x-ray facilities and rehabilitation clinics. The Commonwealth Fund highlighted the need for consolidation control in [Making Health Care Consolidation Work for Patients: An Interview with Commonwealth Fund President David Blumenthal](#). Part of the problem with regulating consolidation, emphasized by David Blumenthal, is that health care is a service and not a distinct commodity like laptops. He hopes that with the aging population increasingly becoming Medicare beneficiaries, the government will gain more leverage to use value-based payment and encourage providers to prioritize quality, safety and equity, not just monetary returns.

A recent American Medical Association study focused on a different aspect of consolidation – in health insurance markets in the report [Competition in Health Insurance: A Comprehensive Study of US Markets](#). In addition to commercial markets, the 2022 edition was the first time Medicare Advantage (MA) markets in metropolitan statistical areas (MSAs) were studied. Since 2017, MA markets have seen a consistent, gradual decrease in concentration, but the current market is still highly concentrated with low levels of competition. According to federal guidelines, at the MSA-level, 3 out of 4 commercial markets and 79% of MA markets were highly concentrated. Health insurers benefit when there are high levels of concentration because they have greater market power and less competition,

which harms consumers and providers of care. The AMA hopes that its researchers can help regulators and lawmakers better scrutinize anticompetitive insurer behavior, especially where there is a distinct lack of competition.

Telehealth

During the pandemic, telehealth or telemedicine transformed from a less-known service to a widely available, popular option for patients. In *Health Affairs*, Shira H. Fischer et. al. discuss the [Use Of And Willingness To Use Video Telehealth Through The COVID-19 Pandemic](#). A national, longitudinal study was conducted around patient willingness to use video telehealth from February 2019 to March 2021. The authors found that across all groups, there was an increase in willingness with the largest changes occurring in the subgroups that had the lowest levels of willingness prior to the pandemic. As telehealth medicine is becoming easier to access with pandemic-related policy changes, Fischer et al. recommend further research into sources of unwarranted variation in patients' willingness to ensure equitable access.

While COVID-19 quickly expanded the scope of telemedicine services and relaxed many regulations, the future of telehealth policies remains in flux. In [Informing the Debate about Telemedicine Reimbursement – What Do We Need to Know?](#), published in the New England Journal of Medicine, Ateev Mehrotra and Lori Uscher-Pines predict Congress will continue to “kick the can” and delay more serious discussion around telemedicine policies. Currently before the Senate is the Advancing Telehealth Beyond COVID-19 Act, which extends pandemic-era telemedicine policies through 2024. The authors argue that normally, delaying important policy decisions is a sign of governmental

dysfunction; however, short-term extensions of telemedicine policies ensure permanent policies are enacted with the best possible evidence. The article points out that necessary research during the short term extension includes (1) whether telemedicine increases spending, (2) whether telemedicine improves patient outcomes, and (3) whether telemedicine advances health equity. As reliance and familiarity with telemedicine continues to grow, Mehrotra and Uscher-Pines conclude that future policy decisions must go beyond coverage decisions.

Value-Based Payment

With more hospitals joining alternative payment models, there has been a concern that it could adversely affect patient selection with hospitals choosing to avoid high-risk patients. Published in *Health Affairs*, [Medicare's Bundled Payments for Care Improvement Advanced Model: Impact On High-Risk Beneficiaries](#) by Karen E. Joynt Maddox, et. al., discusses the outcome of hospitals that participated in Medicare's Bundled Payments for Care Improvement Advanced Model (BPCI-A). The authors examined the impact of BPCI-A among Medicare beneficiaries with frailty, those with multimorbidity, and those dually enrolled in Medicare and Medicaid. While there was a small relative decrease in the proportion of patients with frailty, the study found that there was not consistent evidence of adverse selection nor negative changes in clinical outcomes among patients with medical or social vulnerability for hospitals participating in BPCI-A. The authors concluded that many of the concerns associated with BPCI-A participation in the first year are not supported by their research.