The Future of Community Hospitals in Massachusetts

Peter J. Martin, Esq.

Peter J. Martin, Esq.

Massachusetts health care providers are well aware of the long-term trend of consolidation in the industry – recent examples being Lahey Clinic's pursuit of Elliot Health System in Manchester, N.H., and the proposed merger of two Baystate Health Care facilities – Mary Lane Hospital in Ware into Wing Hospital in Palmer. They are also acutely aware of the price differences between community hospitals and academic medical centers, as described in recent reports issued by the Attorney General's office. A recent report from the Health Policy Commission provides detailed and disturbing information about this trend. The report also suggests that significant regulatory action may have to be taken to try to ameliorate the price-distorting effects of this consolidation trend. The HPC's analysis and suggestions about preserving high-value community-based care options are intriguing and suggest opportunities for collaboration between community hospitals and other provider organizations.

The recent HPC report, "Community Hospitals at a Crossroads," assembles a large number of findings from studies conducted by the HPC and others that collectively paints a dire picture for unaffiliated community hospitals.

For example:

- The five largest hospital systems accounted for 54 percent of commercial payor discharges in 2012 and 61 percent of such discharges in 2014
- 75 percent of all primary care provider visits went to PCPs affiliated with the top eight provider systems, representing 79 percent of all PCP visit revenues in Massachusetts
- Although the cost of a low-risk delivery at a community hospital is 17 percent lower than the same delivery at an academic medical center, six hospitals – five of them with above-average costs – had 53 percent of such deliveries (Partners Healthcare accounted for more than 35 percent of low-risk deliveries)
- Fewer than half of patient discharges at Boston's academic medical centers required AMC-level capabilities

The HPC report also makes the following observations. Most low-acuity services provided by community hospitals are not profitable. Community hospital costs per inpatient stay are, on average, $1,500 less than inpatient stays at AMCs. Having more public-payor patients correlates with lower commercial payor reimbursement rates. If current hospital utilization trends continue, the average community hospital occupancy rate would be 50 percent in 10 years.

Relying on informed consumers to identify and insist on care at lower-cost community hospitals is not likely to be effective, according to consumer surveys and focus groups descried in the HPC report. Survey and focus group participants reported almost no reference to quantitative measures of quality; instead, patients rely on the recommendations of family, friends and physicians. Patients associate lower-cost facilities with "low-budget" care and have greater confidence in physicians who graduated from prestigious medical schools. Patients also have the perception that, having invested significantly in health insurance premiums, they want to "get their money's worth" for that coverage by obtaining care at higher-cost hospitals.

Relying more generally on the market is also not likely to be effective, according to the HPC. Market forces have resulted in the consolidation of hospitals and physician groups into large systems anchored by academic medical centers, and these large systems are able to direct patient referrals to higher-cost facilities. One measure of that ability to steer patients is that every region in Massachusetts experienced a net outflow of patients for inpatient care, except metropolitan Boston. Hospitals with greater market leverage can command higher prices from payors, can use those higher prices to invest in new satellite facilities and the acquisition of physician practices, and can thereby enjoy more patient referrals, at the expense of hospitals with lesser market power. The HPC observes "higher prices that are not tied to quality, complexity, or other common measures of value create costs to consumers, businesses, and the state budget, and threaten the sustainability of lower-priced providers, including many community hospitals."

What is to be done? The HPC report does not specify any particular solutions, but proposes assembling key stakeholders to address three broad themes. First, support the transformation of community hospitals into community-based systems of care. Second, encourage consumers to use high-value providers. Third, create a sustainable, value-based payment system. This is a familiar refrain – providers, patients and payors must all do something to create an efficient, accessible and high-quality health care system. While the suggested payor measures, such as providing financial incentives to patients to choose lower-cost providers, adopting higher-cost differentials between preferred and non-preferred provider tiers and improving risk adjustment models to account for factors that impact community hospital patient populations may have some marginal effect over time, it appears unlikely these steps would significantly or quickly alter the landscape in favor of community hospitals.

Instead, the HPC report strongly suggests that community hospitals need to collaborate with other types of outpatient providers in order to "transform" themselves into systems that align provider types and capacities to identified local health needs. The report mentions limited service clinics, urgent care centers and ambulatory surgery centers as possible partners. The HPC report notes that two-thirds of Massachusetts residents live within five miles of an urgent care center, and three out of five residents live within five miles of a retail clinic. Community health centers and other components of accountable care organizations, as well as social service organizations and behavioral health providers, may also collaborate usefully with community hospitals in an effort to retain patients within the hospital's service area and stem the outflow toward Boston.

If regulatory and reimbursement barriers to this sort of community-based collaboration can be removed or their effects mitigated, community hospitals may have a good chance of reversing the current damaging trends. These hospitals' increasing interest in such partnerships may create opportunities for providers of all types to engage in creative realignments and new structures. Practitioners should keep abreast of these developments to determine how they might fit into these new arrangements.

Peter J. Martin, Esquire, is a partner in the Worcester office of Bowditch & Dewey, LLP, his practice concentrating on health care and nonprofit law.