The coronavirus disease 2019 (COVID-19) crisis has created unprecedented financial strain for health care organizations in the United States. During the early months of the pandemic, nearly all institutions had to reduce or suspend nonessential services to bolster health system capacity, preserve supplies, and minimize viral transmission. While many organizations are now resuming services as restrictions are eased, the volume of services is unlikely to return soon to prepandemic levels because of ongoing infection control measures, widespread economic repercussions, and patients avoiding in-person care. Many organizations may thus experience prolonged shortfalls in revenue.

Congress has authorized more than $300 billion to support health care organizations during the crisis. As of early September, the Department of Health and Human Services had distributed direct payments totaling $78.5 billion (of $175 billion authorized) to approximately 305,000 organizations under the CARES Act Provider Relief Fund. However, these funds and other sources of federal relief may prove inadequate to stave off insolvency for facilities with limited financial reserves.

Initial allocations were predominantly based on organizations' historical revenues, rather than their risk of closure. Remaining shortfalls have left some facilities and physician practices especially vulnerable, particularly those outside of large, hospital-based health systems. Survey data suggest nearly half of physician practices have furloughed staff and nearly one-quarter have implemented permanent layoffs. In the short-term, layoffs and closures could limit patient access to COVID-19 and non–COVID-19 care. In the long run, pandemic-associated financial instability could further accelerate market consolidation.

Consolidation could occur in 3 primary ways: (1) protracted reduction in demand leading to downsizing or closures, thereby increasing the market share of incumbent health care organizations; (2) larger systems and private equity firms with access to capital seeking to acquire distressed organizations at reduced valuations; and (3) physicians leaving struggling practices to join larger organizations with greater financial stability. Such consolidation could raise prices and reduce choices for patients, because dominant organizations may amass bargaining power relative to commercial insurers.

Limiting Pandemic-Induced Provider Consolidation

Consolidation is hard to undo. Any plan to support competition in the long-term must therefore begin with measures to limit clinical consolidation in the short term. To this end, Congress could target additional federal assistance to struggling health care organizations, such as primary care practices and rural hospitals. Ensuring a delivery system that is accessible and equipped to sustain an effective pandemic response could also have a lasting salutary effect on the competitiveness of health care markets.

In addition, public payers could adapt reimbursement to both stabilize practice finances now and cultivate organizational experience with risk contracting for the future. The Centers for Medicare and Medicaid Services has already disbursed approximately $100 billion in accelerated payments to health care organizations based on their historical Medicare revenue. As a next step, the Centers for Medicare and Medicaid Services could expand models with prospective payment elements, such as...
Primary Care First for primary care practices and the Accountable Care Organization (ACO) Investment Model for health care organizations in rural and underserved areas.

Private insurers should share an interest in preserving competition and encouraging lower spending through alternative payment models. However, with a few exceptions, private insurers have largely refrained from taking meaningful action thus far. This may be attributable in part to a free rider problem: when an insurer supports an organization, competing insurers and their enrollees also benefit. Solving this collective action problem may require regulatory nudges or legislation.

Promoting Post–COVID-19 Competition

Financial relief from government and payers alone may prove insufficient to prevent organizational consolidation in the short term. Pushing forward longstanding recommendations to counter consolidation—such as eliminating additional payments to hospital-owned facilities—may be challenging at a time when many dominant health care organizations are financially wounded, even if better positioned than smaller competitors. Other measures will be needed to level the tilted playing field. These should be announced—if not implemented—rapidly, so that organizations and investors can assess their options in a postpandemic health care system. We highlight 2 directions newly motivated by the pandemic.

First, payers could pause mandatory pay-for-performance programs, such as the Merit-Based Incentive Payment System, effective immediately for at least 2 years. These programs have spurred physician practices and newly licensed physicians to join large organizations to offload reporting costs and reduce financial exposure. Pausing these controversial programs would eliminate administrative requirements and financial penalties that disadvantage some practices. Payers could redirect the substantial resources necessary to administer these programs toward high-priority objectives, such as financial relief for health care organizations or redesigning and expanding alternative payment models.

Second, policy could focus on encouraging entry of more efficient delivery models. In particular, technology-enabled primary care groups have the potential to succeed under global budget contracts and compete with large health systems, because use of primary care services determines patient attribution in these contracts and influences an outsized proportion of spending.

Recent relaxation of regulations governing telemedicine could better position primary care–led groups in global budget contracts or capitated payment models to substitute lower-cost modes of care delivery for traditional specialty, inpatient, or postacute care. As risk-bearing organizations, physician groups have stronger incentives than health systems to substitute telemedicine for in-person care, because hospital-based health systems incur offsetting losses in fee-for-service profits when reducing the provision of high-margin services. However, extending payment parity between telemedicine and in-person services beyond the pandemic could diminish the advantage of risk-bearing organizations that deploy telehealth efficiently over those with traditional fee-for-service business models. If telemedicine remains profitable on a fee-for-service basis, incumbent health systems will have stronger incentives to offer virtual care to compete for patients and boost referrals for costly imaging, procedures, and admissions. As policymakers revisit payment policies for telehealth, it will be important to consider the potential for innovative disruption in care delivery.

Concerns about competition in health care markets may seem distant while the pandemic continues to batter the economy and endanger public health. Nonetheless, policymakers now face the threat of crisis-driven consolidation that could shape the delivery system and healthcare spending for years to come. It is time to get ahead of that curve.

ARTICLE INFORMATION

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