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As US hospitals consolidate their pharmacy muscles grow

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Consolidation of hospital chains could give biopharma another powerful group of payers to contend with.

While the biopharma sector has been ringing alarm bells about the power of pharmacy benefit managers to control drug prices it has been silent about another potent US drug buyer – hospitals.

Consolidation of payers has been closely watched, while advocates of cross-sector combinations like CVS's acquisition of Aetna argue that new models of patient care and reimbursement could emerge, in another strike at drug prices. Less well appreciated has been M&A activity among hospitals themselves, which hit a record pace last year, strengthening the purchasing power of this set of important biopharma customers.

A stronger, more organised hospital sector could have both the muscle and the incentive to hold the line on drug spending. New care co-ordination models called "accountable care organisations" (ACOs) being pushed by US government and private payers offer the opportunity for highly integrated health systems to share revenue should they achieve cost-saving targets, making drug prices an area for close examination by hospital executives.

"A consolidated hospital system can be a more aggressive buyer, a more informed buyer," says Paul Ginsburg, the Leonard D. Schaeffer chair in health policy studies at the Brooking Institution. While big systems have been aggressive purchasers for some time, he says, their expanding reach has increased price pressures.

"Mergers mean that smaller [independent] hospitals that didn't have the management wherewithal to [seek lower prices] now can benefit from a large system doing the buying."

Moreover, the ACOs are rated on quality measures such as readmission rates and medication review, thrusting more responsibility on hospital pharmacies to deliver high-value drug therapy to patients.

Record pace

The consulting group Kaufman Hall reports that M&A activity among hospitals and health systems hit a record in 2017, with 115 separate transactions affecting systems with a combined $63bn in revenue. While in the past merger activity had focused primarily on creating regional systems with better negotiating leverage with payers in local markets, more recently not-for-profit hospitals have joined their for-profit brethren in forming national chains.

The biggest of 2017 was the joining of San Francisco-based Dignity Health, which has hospitals in California, Arizona and Nevada, with Catholic Health Initiatives, a national chain headquartered in Colorado. Combined, the two organisations had $28.4bn in annual revenue.

Kaufman Hall says these multi-billion-dollar deals are on the rise: 11 of the health systems that were M&A targets in 2017 had revenues of $1bn or more. The reasons are similar to the forces driving performance in the pharmaceutical sector: price-sensitive payers and reimbursement based on value.

As the consultancy notes, bigger organisations are better positioned to respond to these pressures because they have the financial strength to invest in expensive new technologies that in theory can improve care quality and efficiency, and lower costs.

At the most extreme end, four highly integrated and well-capitalised health systems joined with the US government's veterans' hospitals to seek to lower the costs of generic drugs by forming a not-for-profit generics company (*Interview – Hospital chains seek pricing control, January 25, 2018*).

And, as hospitals merge into ever-larger systems, they are carrying physicians along with them. Their share of physicians in employment rose to 47% in 2016 from 42% in 2012, while those with an ownership stake in their practices fell to 47% from 53%, according to a survey by the American Medical Association. This was the first time the physicians' lobbying group recorded that fewer than half of surveyed doctors had an ownership stake.

Many go into employment by hospitals because they do not want the responsibility of ownership, and also because small independent practices are subject to the same payer price pressure as hospitals.

"You have no leverage with insurers – you are a price taker" as an independent practitioner, says Robert Berenson, a fellow at the Urban Institute. "If they get employed by a hospital their prices double. That amount gets reflected in the compensation they get from the hospital."

Accountable care

Both the integration of hospitals into larger systems and the increasing numbers of physicians employed by those systems are part of a greater transition to ACOs. Formation of these entities was spurred by the Affordable Care Act, which offered to share savings in government spending for ACOs that are able to achieve improvements in 30 measures of quality in treatment of elderly Medicare beneficiaries.

This of course is an incentive to reduce costs, and health system executives will no doubt be looking for ways to achieve savings ranging from reducing how long patients are in the hospital to using their purchasing power to trim the pharmacy bill.

Moreover, quality measures such as rating hospitals on their readmission rates and medication reconciliation – the process of identifying all the drugs a patient takes to prevent dosing errors or drug interactions – could provide an incentive for large systems to create their own speciality pharmacies to improve medication adherence. In turn, this could become a revenue centre for health systems.

A 2016 survey by the Pharmacy Benefit Management Institute (PBMI) found that most ACOs shared in inpatient prescription drug savings, and a majority serving Medicaid and commercial patients also shared in savings from drugs administered in outpatient facilities or by patients themselves. Medicare ACOs were less likely to share in outpatient drug savings because reimbursement for those came from a separate pot of money.

The PBMI survey found that just 35% of ACOs had a formal drug management plan, suggesting room for improvement. Of those that did, common management techniques such as prescribing generic drugs, following clinical guidelines, standardising prescribing patterns and providing doctors with drug cost information were common techniques.

The ACOs were looking to add other protocols, such as moving drug infusions into lower-cost outpatient settings and providing prescribers with information on how much patients will pay for drugs, the PBMI survey found.

And, as ACOs, these systems also have the potential to set themselves up for risk-based contracting with government and commercial payers – that is, sharing in the losses when costs exceed revenue – although only a minority of ACOs are under such strictures now, according to the PBMI survey. If more ACOs go down this road, however, this will only strengthen their role in drug purchasing and management.

The year 2017 ended with worries that non-traditional players like Amazon or Apple would enter drug channels and disrupt the pricing equilibrium. But biopharma needs to be mindful of the players who have always been there – hospitals – as their power also grows.

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