Post-Acute Care and Vertical Integration After the Patient Protection and Affordable Care Act

Patrick D. Shay, doctoral candidate, Virginia Commonwealth University, Richmond, and Stephen S. Mick, PhD, FACHE, professor, Department of Health Administration, Virginia Commonwealth University

EXECUTIVE SUMMARY

The anticipated changes resulting from the passage of the Patient Protection and Affordable Care Act—including the proposed adoption of bundled payment systems and the promotion of accountable care organizations—have generated considerable controversy as U.S. healthcare industry observers debate whether such changes will motivate vertical integration activity. Using examples of accountable care organizations and bundled payment systems in the American post-acute healthcare sector, this article applies economic and sociological perspectives from organization theory to predict that as acute care organizations vary in the degree to which they experience environmental uncertainty, asset specificity, and network embeddedness, their motivation to integrate post-acute care services will also vary, resulting in a spectrum of integrative behavior.
INTRODUCTION

Will acute care organizations integrate vertically with post-acute care providers as a result of the changes ushered in by the Patient Protection and Affordable Care Act of 2010 (ACA)? This prospect may be facilitated by the promotion of accountable care organizations (ACOs) and bundled payment systems in the post-acute healthcare sector. We elaborate on this possibility on the basis of contrasting conceptual schemes, providing two avenues that highly differentiated organizations may pursue when facing an integration decision. Our argument is that an acute care organization’s motivation to integrate post-acute services will vary commensurate with the degree to which it is embedded in a network of related organizations given an environment of heightened uncertainty and asset specificity.

The ACA ushered in a series of reforms and changes that have begun to alter the American healthcare landscape. We examine two aspects of the ACA—ACOs and bundled payment programs—as changes that may have a dramatic impact on healthcare organizations and the post-acute care sector. Of the many provisions included in the ACA, we focus on these two reforms given their shared purpose of promoting quality while controlling spending—needs prescribed for the post-acute care sector in light of its rampant growth and fragmented nature—and their identity as the two prominent payment reform provisions demanding heightened coordination of services between acute and post-acute providers (e.g., Dresevic & Kalmowitz, 2011; Taft, 2010). Some industry observers expect healthcare organizations to consolidate in response to these changes (Goldsmith, 2011; Zigmond, 2010; Greis, Rawlings, & Jackson, 2009; Welch, 1998), with vertical integration comprising a major form of consolidation. Vertical integration is commonly reduced to “make or buy” arrangements in which organizations decide to internalize their production and distribution procedures rather than purchase materials or services from the market (Diana, 2009; Harrigan, 1985). Applying such arrangements to patient care, this article defines vertical integration as the provision of a continuum of office-based primary care, acute care, and post-acute services within a single organization or joint ownership structure, allowing for a coordinated progression of services across the patient care spectrum. Although the acute care hospital need not necessarily be the focal organization involved in vertically integrating other health services units, it is the most common strategic business unit among the continuum of health services units, with the human and financial resources required for such ambitious organizational change (Mick & Conrad, 1988). Therefore, we study the question of vertical integration of post-acute care services from the perspective of the acute care facility. Following the promotion of ACOs and bundled payment programs as ACA provisions, most observers have focused on the potential for integration between hospitals and physician practices (e.g., Keckley & Hoffmann, 2010; Shortell, Casalino, & Fisher, 2010; Weinstock, 2010), with trends already pointing to an increase in hospital–physician integration activity (Tocknell,
2012). However, little attention has been devoted to examining post-acute care as a potential area for vertical integration, and to address this gap, we focus on acute care hospitals’ integration of post-acute care services.

**Why the Vertical Integration Choice Is Important**

Does it really matter whether or not acute care organizations increasingly integrate with post-acute care organizations following ACA reforms? Proponents of vertical integration suggest that vertically integrated organizations enjoy enhanced efficiencies and reduced expenses through economies of scale (Walston, Kimberly, & Burns, 1996; Conrad, 1992). Thus, vertical integration is valued for its perceived ability to enable better continuity of care while economizing on administrative expenses (Conrad, 1992). To such advocates of vertical integration, the aspects of the ACA that promote integration activity may be viewed as beneficial to the healthcare system in their ability to promote greater efficiency, quality, and effectiveness among providers.

On the other hand, critics of vertical integration point to lessons learned in the healthcare industry during the end of the 20th century as many integrated organizations experienced increased costs and failed to realize anticipated benefits, including prominent organizations such as Humana and Allina (Luke, Walston, & Plummer, 2004; Walston et al., 1996). The potential costs of vertical integration, including increased start-up and learning costs, competitive backlash, and a “lack of attention to community and social goals,” may outweigh any anticipated benefits (Clement, 1992, p. 104). Additionally, and often not recognized, *internal* transaction costs develop inside organizations, especially in vertically integrated organizations (Mick, 1990; Mick & Conrad, 1988).

In the burst of vertical integration that accompanied the managed care and integrated delivery system revolution of the 1990s, administrative costs skyrocketed due to a lack of experience and poor management of these increasingly complicated organizational arrangements, including the confusion and expense stemming from the implementation of effective electronic management and clinical control systems.

Furthermore, the consolidation of providers as a result of integration bears significant consequences within local healthcare markets, specifically in regard to the concentration of market power. Evidence suggests that consolidation of healthcare organizations leads to higher prices (Town, Wholey, Feldman, & Burns, 2006), although this verdict is not unanimous (Moriya, Vogt, & Gaynor, 2010). Robinson (1996b, p. 166) argues that, in times of “rapid technological and market change,” vertically integrated organizations sacrifice the flexibility and autonomy gained through contractual relationships and embedded networks, thereby exacerbating expenses and inefficiencies among healthcare organizations. Elsewhere, he concludes that, at the worst, vertical integration may lead to “managerial arrogance at the top, a civil service mentality among physicians, and a corporate culture of growth, merger, and acquisitions as ends in themselves” (Robinson, 1997, p. 8). Those who are skeptical...
of the benefits of vertical integration suggest that the aspects of the ACA that promote integration activity may actually yield unintended consequences in the forms of heightened expenses and inefficiencies—the same problems that such reform aims to address—to the detriment of the healthcare industry and the communities it serves (Robinson, 1997). Thus, the prospect of vertical integration following healthcare reform is one that needs to be carefully evaluated given the diversity of views about the performance possibilities that might ensue.

**BACKGROUND**

The post-acute care sector is a substantial element of the U.S. healthcare system, providing a range of services for patients following their acute care hospitalizations. Post-acute service providers include home health agencies, inpatient rehabilitation facilities, long-term acute care hospitals, skilled nursing facilities, and outpatient rehabilitation clinics, all of which seek to expedite the recovery process of patients, ease their transition back into the community, and restore them to their previous level of functioning (Buntin, Colla, & Escarce, 2009; CPS, 2009). Over the past 30 years, demand and utilization of post-acute care services in the United States have increased significantly, yielding tremendous growth and development of post-acute care providers and, with them, significant problems within the post-acute care sector (Buntin et al., 2009; Yip, Wilber, & Myrtle, 2002). Recent attempts by the U.S. Congress to rein in soaring post-acute care expenses and promote greater efficiency include the gradual introduction of individual prospective payment systems (PPSs) for each post-acute care setting, starting with the Balanced Budget Act of 1997 (BBA). However, post-acute care facilities have learned to manage patient costs and profit margins under newly fixed reimbursements by accelerating patient discharges to other segments of the post-acute care sector providing substitutable services.

The substitutability of post-acute services is traced to the mid-1980s, when acute care facilities began a pattern of discharging patients more quickly than in the past. This trend led to increased demand for post-acute services, and post-acute settings responded by expanding their offerings to treat patients with higher acuity levels, often resulting in overlapping services (Zinn, Mor, Feng, & Ittintro, 2007; Banks, Parker, & Wendel, 2001). As separate PPSs for each post-acute setting were introduced following the BBA, post-acute care sites were motivated to accelerate patient discharges, and providers took advantage of the substitutability of post-acute services by shifting patients between settings (Welch, 1998). Today, the post-acute care industry expects more than one half of its patients to bounce back and forth between two or more types of post-acute sites during a single episode of care, thereby encouraging overutilization while requiring redundant treatments, assessments, and documentation for patients (CPS, 2009). In light of such redundant services and an increase in patient acuity, post-acute providers display general confusion and a “lack of clinical consensus” in determining the appropriate setting for patients (Buntin et al., 2009,
p. 1190). The post-acute care sector is also criticized for being fragmented or siloed—a term used in post-acute care to refer to the separate identities, cultures, and standards maintained by each setting. The separate payment systems and regulatory standards recently introduced for each post-acute setting have further reinforced their individual identities and fostered strong competition among them for the same patients and resources (AMRPA, 2009; CPS, 2009; Currie, 1996). Aware of the redundant, fragmented, inefficient, and expensive state of the post-acute care sector, U.S. healthcare policy experts recently focused on ways to improve patient care while reducing expenses through Medicare payment system reform (Galewitz, 2009). Concepts that have received growing interest and endorsements over the past five years include two elements incorporated into the ACA: bundled payment systems and ACOs (Berenson, 2010; CPS, 2009; Devers & Berenson, 2009; Lubell, 2009).¹

**Bundled Payments**

The concept of bundled payments is admired for its seeming simplicity and promotion of a holistic approach. Rather than pay each provider for separate services provided to a patient during an episode of care, the bundled payment system defined in the ACA would pay one provider a single payment for all services the patient received during the entire episode, including post-acute services received within 30 days of an acute care hospital discharge. The entity receiving the bundled payment would then divide the reimbursement to pay each contributing provider the amount deemed appropriate for the services rendered. Healthcare facilities would realize no payment incentive to shift patients between post-acute settings, thereby addressing problems of inefficiency and redundancy that substitutable care has created (Welch, 1998).

Section 3023 of the ACA requires the secretary of the U.S. Department of Health and Human Services (HHS) to establish the National Pilot Program on Payment Bundling by January 1, 2013, to include expenditures related to acute care inpatient services, physician services, outpatient hospital services, and post-acute care services provided to Medicare beneficiaries. Should the project succeed, Medicare will likely expand the bundled payments concept to all post-acute care providers and services (Galewitz, 2009). Although no decision has been made regarding how a bundled payment system ultimately will be implemented, many observers suggest that acute care facilities will be the most likely recipients of bundled payments (Galewitz, 2009; Greis et al., 2009; Lubell, 2009; Murer, 2009), citing recommendations by the Congressional Budget Office (CBO, 2008, p. 62). Thus, for purposes of this article, we assume that bundled payments will be directed to acute care hospitals, which will be responsible for disbursing reimbursements to contributing providers.

**Accountable Care Organizations**

Section 3022 of the ACA requires the secretary of HHS to have created the Medicare Shared Savings Program (MSSP) by January 1, 2012, for providers participating as ACOs; this program was established on November 2, 2011,
as a final rule in the Federal Register. The concept of ACOs has been recently promoted as a means to pair cost reduction reform with efforts to improve quality (Devers & Berenson, 2009). ACOs are provider-led organizations that are responsible for a defined population and that manage the full continuum of care for participating patients, overseeing the overall cost and quality of care (Keckley & Hoffmann, 2010; Shortell et al., 2010; Devers & Berenson, 2009; Rittenhouse, Shortell, & Fisher, 2009). ACO participants in the MSSP can share a portion of Medicare’s realized savings—essentially receiving bonus payments—by meeting quality benchmarks and reducing expenditures below spending projections. Although guidelines for participation are fairly general, organizations seeking to comply with Section 3022 of the ACA and participate as ACOs must be able to either provide or arrange for the provision of the full continuum of care for at least 5,000 Medicare beneficiaries.

Many policy experts and representatives of the post-acute care sector expect bundled payments and ACOs to improve efficiency, coordination, and cost-effectiveness, mitigating some of the unintended consequences of past post-acute payment systems (DeVore & Champion, 2011; Craver, 2010; CPS, 2009; Galewitz, 2009; Terry, 2009; Welch, 1998). However, despite general support among them for ACOs and bundled payments, many involved remain uncertain regarding the effects of such reimbursement changes. As acute care hospitals become responsible for the coordination and payment of all patient care following the introduction of bundled payments, they will face the make-or-buy decision of whether to provide post-acute services directly to patients or develop contractual arrangements with post-acute care providers to allow patients to receive post-acute services outside of the acute care facility (Murer, 2009; Banks et al., 2001; Welch, 1998). Considering this scenario, some scholars anticipate that the implementation of bundled payments will encourage acute care and post-acute care organizations to integrate vertically to realize production efficiencies and ensure survival (Greis et al., 2009; Banks et al., 2001; Byrne & Ashton, 1999). Similarly, organizations considering the ACO model must choose whether to develop long-term relationships with external entities (including post-acute care providers) to form an ACO or make the “commitment to ‘make’ rather than ‘buy’” (Keckley & Hoffmann, 2010, p. 18).

TWO DISTINCT STRATEGIES

In response to the question of whether organizations are likely to pursue vertical integration, two prominent organizational theories—transaction cost economics (TCE) and network theory—suggest two distinct strategies firms may pursue following ACA reforms.²

Transaction Costs

Proponents of TCE claim that, under uncertain market circumstances in which the asset specificity of transactions is both idiosyncratic and recurring, vertical integration is preferred over market exchanges because the former produces lower transaction costs than the latter does (Mick & Conrad, 1988; Williamson, 1975). Asset specificity is the phenomenon of an organization being “locked in” to
a relationship with another organization because the resources it invested in the relationship would be of lesser value if they were invested in other relationships (Scott & Davis, 2007). Examples of asset specificity related to transactions between acute care and post-acute care organizations are physical and human capital, brand names, and time. The promotion of ACOs and bundled payments may heighten such forms of asset specificity in exchange relationships between acute care and post-acute care organizations. For example, as acute care facilities invest in equipment, personnel, and “infrastructure for effective care coordination” with post-acute organizations participating in their ACO or as bundled payment partners (CMS, 2011, p. 19638), the levels of physical and human asset specificity in their exchange relationship may increase. As organizations consider forming or joining ACOs, providers with valuable brand names must decide whether they approve of associating their brand with other ACO participants. Furthermore, as ACOs and bundled payments increase pressure for providers to attend quickly and carefully to beneficiaries’ transitions across settings, acute care hospitals may integrate vertically with post-acute care providers to address high temporal asset specificity, allowing them to “evaluate admissions and discharges from the perspective of the integrated organization” rather than that of an independent care provider (Robinson, 1996a, p. 361).

In the presence of asset specificity, TCE maintains that an increase in uncertainty creates a primary motivation to integrate (Joskow, 2008). Within today’s complex post-acute care sector, an environment perceived to be chaotic and confusing (AMRPA, 2009), the implementation of ACOs and bundled payment systems is likely to engender an even greater sense of uncertainty among providers, motivating increased consolidation for the next several years (Harris, Grauman, & Hemnani, 2010; Zigmond, 2010; Zuckerman, 2009). Acute care entities may pursue vertical integration with post-acute care organizations to gain competitive advantage, control patient flow through service offerings, and offer a full continuum of services that meet a patient’s needs for an entire care episode. Vertical integration may also address increased uncertainty in the form of opportunistic behavior among acute care and post-acute care facilities that participate together in ACOs or share bundled payments.

To limit opportunistic behavior, bundled payments and ACOs will require the development of a high level of infrastructure to address system needs and contingencies, including legal, technical, and financial arrangements (DeVore & Champion, 2011; Keckley & Hoffmann, 2010; Shortell et al., 2010; CPS, 2009; Lubell, 2009). Such infrastructure demands time and resources that will increase transaction costs for participating providers. By integrating vertically, the transaction costs associated with continuous negotiating and monitoring efforts may be reduced. Vertical integration may also address the heightened uncertainty resulting from providers’ exposure to various risks following the adoption of bundled payment systems or ACO models. Before bundled payment schemes emerged, acute care facilities did not assume financial risk for the future costs and
potential complications of patients following their discharge to post-acute settings. However, by tying reimbursements together for an entire episode of care, increased patient costs or future complications in post-acute settings create an increase in the overall costs for a patient’s episode of care. Therefore, an acute care facility sharing a bundled payment with external post-acute care facilities assumes the financial risk that patient costs may exceed expectations following acute care discharge despite their best efforts (Jackson, Greis, & Rawlings, 2009). As the acute care and post-acute care facilities look to divide the bundled payment, increased overall patient costs may take away from the acute care facility’s portion of the bundled payment. Similarly, acute care providers participating in ACOs may face considerable challenges in the event they must manage beneficiaries’ care received from post-acute care providers outside of the ACO (CMS, 2011). For example, post-acute care providers operating outside of an ACO may adopt patient care philosophies or treatment decisions that conflict with the ACO’s preferences, and the ACO may lack the ability to enforce its preferences on independent post-acute care providers. Such post-acute care providers would not be obligated to support the ACO and would be able to operate under a presumption of autonomous interests. For these risks, vertical integration may address providers’ uncertainties by aligning the interests of the acute care and post-acute care facilities as a single organization.

Thus, we suggest that an overall effect of ACO and bundled payment policies will be to increase uncertainty throughout the healthcare industry, particularly within the post-acute care sector. When combined with exchanges of high asset specificity, this overall increase in uncertainty will pressure many organizations to integrate vertically in response.

Proposition Following the implementation of ACOs and bundled payments in the post-acute care sector, vertical integration between acute and post-acute care organizations will increase as a result of increased environmental uncertainty and asset specificity.

Network Embeddedness
In contrast to the predictions of vertical integration promoted by TCE, network theory suggests that organizations embedded within networks enjoy economic opportunities that do not require a vertically integrated organizational form (Uzzi, 1997). Networks are “the informal connections” among organizations “that often arise out of work patterns but can have a large influence beyond them” (Scott & Davis, 2007, p. 23). In that context, embeddedness is defined as the degree to which an organization maintains links or relational ties with other organizations throughout its network, thereby influencing organizations’ economic activities through consideration of social factors and relations (Dacin, Ventresca, & Beal, 1999). As opposed to the distant and impersonal arms-length ties that characterize transactions within ideal markets, embeddedness leads to close and personal exchanges among independent organizational entities that do not require complicated organizational systems but are characterized by high levels of trust, information transfer, and
joint problem-solving arrangements (Uzzi, 1997). As a result, asset specificity and environmental uncertainty are less problematic than they would be otherwise because opportunism and deception by one organization are much more difficult to conceal from another embedded organization in its network (Robinson, 1997; Uzzi, 1997). In addition to discouraging opportunism, embedded network relationships foster ethical values and mutual support among exchange partners (Podolny & Page, 1998). Each organization’s success depends on the success of the network, motivating members to develop the trust necessary to share access to privileged resources in order to enhance the overall competitiveness of the network.

An examination of how embedded organizations may react to ACA reforms highlights the ways in which such organizations are uniquely positioned to meet the challenges of uncertainty and asset specificity without requiring vertical integration. For embedded healthcare organizations, the introduction of bundled payments and ACOs will not produce fears of opportunistic behavior, as acute care organizations will trust that cooperating post-acute care facilities will continually seek to advance the network’s competitive standing. Transactional details and monitoring activities are no longer needed to protect against opportunism and behavioral uncertainty, as embedded organizations find little strategic motivation to behave opportunistically and instead operate on conditions of trust (Podolny & Page, 1998; Uzzi, 1997; Provan, 1993). Rather than questioning whether physicians and patients will continue to demand their services following ACA reforms, embedded organizations will alleviate their uncertainty by strengthening their relationship with post-acute care providers they depend on to provide a full continuum of services (Podolny & Page, 1998). Concerns about corporate strategy needs and service offerings will be addressed by the enhanced competitiveness, legitimacy, and quality enjoyed as a result of network embeddedness and the valuable information exchange and joint problem-solving commitment it provides (Podolny & Page, 1998). Furthermore, the uncertainty and risk of forging new contractual agreements in ACOs or bundled payment systems will have been addressed by the ethical orientation guiding the exchange partner relationship, as buyers and sellers “make relationship-specific investments without contractual guarantees protecting those investments” because they trust each other to act in the interest of the network rather than self-interest (Podolny & Page, 1998, p. 60). As a result, bargaining power is no longer sought, as embedded organizations are willing to exceed “the letter of a contract” and engage in joint problem-solving efforts rather than bargaining activities (Uzzi, 1997, p. 51). With sources of uncertainty within idiosyncratic exchange relationships addressed by the benefits of network embeddedness, factors that dictate integration decisions following ACA reforms are seen in a different light by organizations.

**Proposition** Following the implementation of ACOs and bundled payments, acute and post-acute care organizations exhibiting greater degrees of network embeddedness will be less likely to integrate vertically.
CONCLUSION
A consideration of economic and sociological perspectives highlights the different directions that an organization may take in its integration activities depending on the organization’s environmental uncertainty, asset specificity, or network embeddedness. As organizations vary in the degree of their environmental uncertainty and their network embeddedness, their approach to integration decision factors will also vary, resulting in a spectrum of integrative behavior. Figure 1 summarizes the two opposing theoretical perspectives’ predictions for organizations in response to the

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<th>Anticipated Changes</th>
<th>Predicted Responses</th>
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<tr>
<td>Patients may prefer care from providers offering a full continuum of care</td>
<td>TCE: VI encouraged to enhance organizational service offerings</td>
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<td>Network theory: VI not required for embedded organizations maintaining strong relationships with PAC providers</td>
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<tr>
<td>Infrastructure (e.g., legal, technical, financial) may be required to discourage opportunistic behavior among accountable care organization and bundled payment partners</td>
<td>TCE: VI encouraged to reduce transaction costs of monitoring and negotiations</td>
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<td>Network theory: VI not required for embedded organizations operating on conditions of trust with network members and resisting opportunistic behavior</td>
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<tr>
<td>Competitors may pursue new reforms as a strategic means to enhance competitiveness, legitimacy, and quality in the marketplace</td>
<td>TCE: VI encouraged to ensure competitive advantage over other market competitors</td>
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<td>Network theory: VI not required for embedded organizations that enjoy enhanced competitiveness, legitimacy, and quality as a result of network information sharing and joint problem solving</td>
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<tr>
<td>Acute care and PAC providers may realize competing interests, philosophies, preferences, or treatment decisions</td>
<td>TCE: VI encouraged to align interests of PAC providers with acute care organization</td>
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<td></td>
<td>Network theory: VI not required for embedded organizations guided by ethical orientation toward network members rather than motivations driven by self-interest</td>
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environmental changes resulting from bundled payments and ACO models.

This article’s predictions are solely theoretical and require both time and data to be empirically tested. As expressed by some post-acute care industry representatives, the introduction of ACOs and a bundled payment system may indeed yield anticipated outcomes, but it will also surely create unanticipated consequences that will require further attention. Perhaps this is to be expected for a sector of the healthcare industry that has already experienced considerable regulation and change. As has always been the case, in today’s post-ACA healthcare industry, “there are prone to be significant winners and losers” (CPS, 2009, p. 16). Who will win and who may lose, however, remains an issue of uncertainty.

NOTES
1. First introduced in the 1980s, a bundled payment model incorporating post-acute care as a model of interest was revived following a report by the Congressional Budget Office in December 2008 proposing ways to reduce federal healthcare spending. Elliott Fisher and colleagues first proposed the concept of ACOs in 2006 as a means to encourage Medicare savings and improve quality of care through heightened accountability and performance measurement (Fisher, Staiger, Bynum, & Gottlieb, 2006).

2. Several organizational theories speak to organizations’ motivations to integrate, including the popular resource dependence perspective (Mick, 1990). However, as resource dependence theory views vertical integration as a possible response to the management of organizational interdependence, emphasizing organizations’ desire to enhance power and autonomy in interorganizational relationships (Scott & Davis, 2007), TCE more directly addresses organizations’ decisions to draw organizational boundaries or integrate. In this sense, TCE may be considered a subtheory of the resource dependence perspective as it explains vertical integration (Mick, 1990). Given its focus, we employ a TCE perspective to predict integration behaviors. Additionally, frameworks such as resource dependence theory are largely silent on the contrasting relationship between vertical integration and network embeddedness.

REFERENCES


**PRACTITIONER APPLICATION**

Craig Garner, JD, chief executive officer, Garner Health LLC, Santa Monica, California

In his classic tale “The Sneetches,” Theodor Seuss Geisel (Dr. Seuss) created a society divided by entitlement in which the lines of separation were removed, thrusting its members together. A satire about discrimination, “The Sneetches” offers children an early introduction to the arbitrary walls that those forces governing society can build and destroy at their whim.
Shay and Mick may be said to describe a similar scenario as they apply provisions of the 2010 Affordable Care Act (ACA) to post-acute care and vertical integration under the Medicare Shared Savings Program (also known as accountable care organizations or ACOs) and to bundled payment systems. They note that these are the areas in which the influences of the ACA are most apparent. In the process, Shay and Mick remind us that perception is formed largely on the basis of factors lurking beneath the surface that care little for public opinion. For example, much like Dr. Seuss’s Sneetches, Hurricane Sandy, which struck the East Coast shoreline in October 2012, rendered the “haves” and “have nots” almost indistinguishable. Bellevue Hospital, the oldest hospital operating in the United States, was capable of offering roughly as much care during and immediately following the hurricane as it was in 1736, when the New York City Almshouse designated six bedrooms as Bellevue’s first “ward.”

During my 9-year tenure as CEO of a community hospital in Los Angeles County, California, bundling was still considered a pejorative term and vertical integration was lost somewhere in the abyss between Stark I and Stark III. As ours was a small hospital with a busy emergency department and no managed care contracts, patients usually left soon after stabilization, either on their own two feet or when transferred by the payer to a contracting facility. Vertical integration had little impact on my day-to-day operations. I cannot say how I would have reacted to ACOs or even this article then—at least until I took the time to review the application to become an ACO (see below).

In today’s healthcare climate, however, I hold hope that patients will come to expect a full continuum of services for an entire care episode in a single institution or ACO. While most acute care facilities now focus attention on the Hospital Value-Based Purchasing program in an attempt to reduce the number of readmissions and unexpected outcomes, the final narrative question contained in the ACO application remains too important to be ignored by anyone in the healthcare sector:

Submit a narrative describing how the ACO defines, establishes, implements, evaluates, and periodically updates its care coordination processes. Also describe: a. The ACO’s methods and processes to coordinate care throughout an episode of care and during care transitions, such as discharge from a hospital or transfer of care from a primary care physician to a specialist (both inside and outside the ACO) . . .

Absent from this final section is any hint of concern about the dangers resulting from vertical integration, not to mention the economic and sociological directions an organization may be forced to follow as it integrates. While the authors raise pertinent questions relating to the future of modern American healthcare, the answers they seek may not be available until the ACA has had time to mature and align itself with the unspoken demands of the industry.