

## *Hospital Consolidation: “Safety in Numbers” Strategy Prevails in Preparation for a Value-Based Marketplace*

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One of the most significant unintended consequences of the passage of the Affordable Care Act (ACA) in March 2010 has been the ignition of another wave of consolidation activity among U.S. healthcare providers. Similar to the industry’s response to the threat of managed care in the mid-1990s, merger and acquisition (M&A) activity between multihospital health systems, stand-alone hospitals, large multispecialty medical groups, small independent physician group practices, and other provider organizations has accelerated dramatically in response to the ACA. According to Irving Levin Associates, the number of hospital mergers alone more than doubled between 2009 and 2012 (Creswell & Abelson, 2013). Tracking physician consolidation nationally is less precise, but Medical Group Management Association survey data suggest that the percentage of physicians working in practices owned by a hospital or an integrated delivery system increased from 24% in 2004 to 54% in 2012 (MGMA, 2013).

At the end of the last wave of consolidation, by 2000, the overall percentage of hospitals in systems had increased from 38% to 52%. And since the Great Recession and passage of the ACA, nearly another 400 hospitals (10% of U.S. community hospitals) had joined multihospital systems and the percentage of hospitals in systems had increased to 62% by the end of 2013 (AHA, 2014). Additionally, these figures do not include the substantial number of “announced transactions” that ultimately were never consummated. For a variety of factors (cultural, political, legal, and regulatory), transactions between nontaxable entities are significantly more time consuming, unpredictable, and difficult to close than are mergers between taxable entities. In spite of the challenges of successfully executing merger strategies, it seems that nearly all hospitals and health systems, from organizations worth \$100 million to those worth more than \$1 billion, are asking, “Are we big enough to not merely survive, but to thrive, in the emerging postreform environment?”

Intended to reduce the fragmentation of care delivery (thereby improving quality and reducing cost), the ACA has triggered market forces that are working to essentially flip the provider-side business model from fee-for-service (FFS) to value-/risk-based reimbursement models (e.g., accountable care/shared savings, bundled payments, partial or full capitation arrangements). This shift is akin to auto insurers telling auto

body shops that over the next few years the shops will increasingly be paid to *prevent* auto accidents rather than earn fee-for-service revenues to repair damaged vehicles. Traffic safety is no more a core competency for auto body shops than wellness, prevention, and care coordination are for most community hospitals. Hospitals seeking to “go it alone” face a daunting level of investment in both financial and human resources to build the infrastructure and capabilities required to shift from an acute event-driven “sick care” system to a proactive prevention and care coordination mind-set.

Although the respective financial strength of both parties is certainly a key consideration in any business combination, pursuit of a merger to simply create a “fortress balance sheet” is not sufficient to position an organization for success in the value-based marketplace. One of the lessons of the Great Recession is that even the most unassailable community hospital balance sheets can be compromised in a shockingly short period. In addition to shoring up the balance sheet, many hospital transactions have been justified in the pursuit of economies of scale. The literature suggests, however, that many, if not most, M&A transactions do not achieve the desired results. In fact, the most recent data released by the Synthesis Project, an ongoing national study by the Robert Wood Johnson Foundation, suggest that consolidation (absent true integration) does not lead to cost reductions or clinical improvement and may lead to enhanced market power for providers (Gaynor & Town, 2012).

Conducting the analytics to quantify potential merger synergy opportunities (e.g., supply chain, revenue cycle, IT) is an important, if rather straightforward, math exercise. However, designing and implementing an optimal governance and organization structure that (a) reflects unique cultures and (b) is nimble enough for a new multihospital system to quickly respond to market opportunities (and threats) requires a much more foundational and nuanced conversation.

Interestingly, both financially distressed providers and well-positioned, AA-rated health systems with significant financial reserves are pursuing partnership strategies. For example, Cadence Health (2014), in the western suburbs of Chicago, recently signed a definitive agreement to join Northwestern Memorial HealthCare. With more than 500 days cash on hand and consistently strong operating margins, Cadence has one of the strongest financial profiles of any AA-rated health system in the United States. A two-hospital system with a rapidly growing employed medical group, Cadence has been phenomenally successful in the FFS environment but is proactively joining a larger system to help position the organization for continued success in the emerging value-based marketplace (Reuters, 2013). Atlantic City, New Jersey-based AtlantiCare’s recent decision to merge with Danville, Pennsylvania-based Geisinger Health System is another example of a high-performing organization seeking a partner to navigate the transition to a value-based environment. AtlantiCare selected Geisinger because it is a “national model for innovation and value that is on the leading edge of transforming healthcare,” according to David Tilton, FACHE, president and CEO of AtlantiCare (PR Newswire, 2014).

Well-conceived and properly executed health system transactions have the ability to deliver greater value than ever before and to strengthen an organization’s positioning

for value-based competition. Beyond financial and scale considerations, visionary governing boards and management teams are now also evaluating potential partners on key factors such as the ability to safely navigate the transition from FFS to value-/risk-based reimbursement models and the combined ability to coordinate care for a critical mass of a defined population (as measured by the number of attributed lives in their primary care network, not inpatient discharges). Key questions to be addressed include the following: (a) How can a strategic partner help transform the organization from a hospital-centric, episodic care delivery model to a patient-centered, integrated care system? (b) What percentage of current/projected revenues for the combined entity will be driven by value-based contracts? (c) What is each respective party's appetite for risk (e.g., entering into risk-based contracts; launching a provider-sponsored health plan)? (d) If the combined partners were to take on risk for a defined population, what services are not currently provided by either party in the network?

Migrating from the current transactional FFS system to a value-based model will require transformational change for all but a handful of health systems across the United States. The best-positioned organizations, such as Geisinger Health System, Intermountain Healthcare, and Kaiser Permanente, have spent decades refining their integrated care delivery models. The operational challenges confronting administrative and clinical hospital leaders cannot be overstated as the fundamental economic model shifts from volume-driven FFS visits and days to value-driven episodes of care and chronic disease management. The challenge is further compounded by the fact that the shift is occurring piecemeal, one payer and one contract at a time, thus forcing hospitals to operate in both the volume- and value-driven models simultaneously. Today's safety-in-numbers M&A strategy finds organizations seeking like-minded strategic partners that, combined, can effectively walk the tightrope from a volume-driven to a value-driven marketplace.

## REFERENCES

- American Hospital Association (AHA). (2014, January). *Fast facts on US hospitals*. Retrieved from <http://www.aha.org/research/rc/stat-studies/fast-facts.shtml>
- Cadence Health. (2014, May 15). Northwestern Memorial HealthCare and Cadence Health reach definitive agreement to combine health systems. Retrieved from <http://cadencehealth.org/About-Cadence-Health/Newsroom/Press-Releases/Northwestern-Memorial-HealthCare-and-Cadence-Health.aspx>
- Creswell, J., & Abelson, R. (2013, August 12). New laws and rising costs create a surge of super-sizing hospitals. *New York Times*. Retrieved from <http://www.nytimes.com/2013/08/13/business/bigger-hospitals-may-lead-to-bigger-bills-for-patients.html#h>
- Gaynor, M., & Town, R. (2012, June). The impact of hospital consolidation. *The Synthesis Project Update*. Retrieved from <http://www.rwjf.org/en/research-publications/find-rwjf-research/2012/06/the-impact-of-hospital-consolidation.html>
- Medical Group Management Association (MGMA). (2013). Demographics-medical practice table 8: Organization ownership. In *Physician compensation and production survey: 2013 report based on 2013 data*. Englewood, CO: Author.
- PR Newswire. (2014, May 27). AtlantiCare and Geisinger health systems sign definitive agreement. Retrieved from <http://www.prnewswire.com/news-releases/atlanticare-and-geisinger-health-systems-sign-definitive-agreement-260762321.html>
- Reuters. (2013, January 31). Fitch affirms Central DuPage Health, Ill. revs at 'AA'. Retrieved from <http://www.reuters.com/article/2013/01/31/idUSWNB002WH20130131>