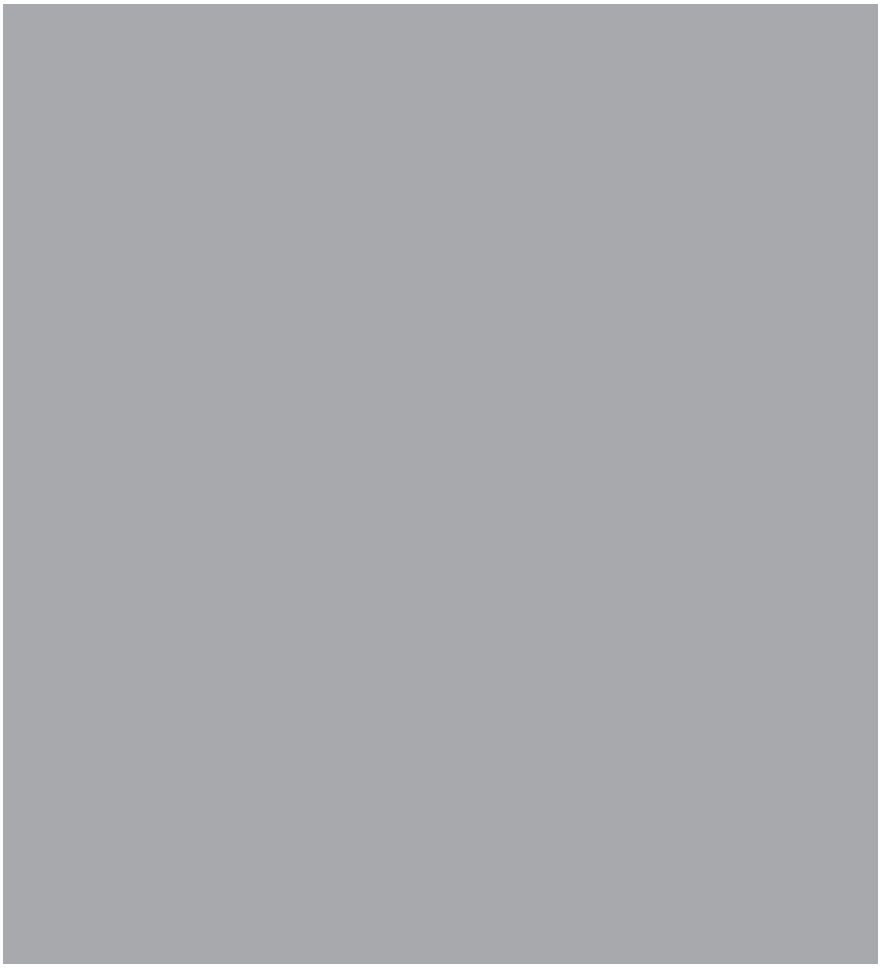
For Better, Not Worse

With market forces pushing mergers, smaller communities are seeing benefits

By David Burik and Monte Dube



Love at first sight. Sometimes the couple heads straight down the aisle. More often, though, the courtship takes a little while, or even a long while. Look, for example, at the lengthy, tortuous mating dance between Camden-Clark Memorial Hospital and St. Joseph's Hospital, located less than a mile apart in Parkersburg, W.V., a town of 31,000 in the Mid-Ohio Valley.

Camden-Clark, founded in 1898 as a city-owned facility, was privatized into a locally operated nonprofit corporation almost 15 years ago. St. Joseph's opened as a Catholic hospital, also at the turn of the last century. In 1996, the Sisters of St. Joseph transferred operations into a for-profit joint venture it co-owned with HCA; over the next two decades, St. Joseph's ownership transferred outright to HCA, and then to two other for-profits, Nashville-based Lifepoint Hospitals, and then to Signature Hospitals, a three-hospital Texas chain.

As with so many two- or three-hospital towns, St. Joseph's and Camden-Clark duplicated most everything: two labs, two medical staffs and two sets of senior management, but with two separate cultures. The effects of head-to-head competition littered the landscape; routinely, each organization's attempt to add services or major capital improvements was contested fiercely through West Virginia's highly prescriptive certificate-of-need and rate-setting processes. Competition, not collaboration, was the paradigm which predominated in this health-delivery system. Meanwhile, Parkersburg's number of beds was ## per thousand, in contrast with the natural average of ## per thousand.

Starting in the 1980s, when Camden-Clark was still city-operated and St. Joseph's still Catholic, their boards and management initiated discussions about how a consolidated Parkersburg-based health system might benefit the communities they both served. But church-state issues were insuperable obstacles to a merger. Years later, as a series of for-profit owners of St. Joseph's sought buyers for the facility, Camden-Clark could never quite find enough money to

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outbid its competition.

That is, until March, when West Virginia United Health System, the state's largest health system, helped to subsidize the purchase of St. Joseph's from Signature, and simultaneously affiliate with Camden-Clark into its nonprofit family of hospitals. (WVUHS obligated itself for $25 million and obligated the entire system for the debt.) Today, at long last, Parkersburg's head-to-head competitors have come together into a one-hospital, two-campus, regional health care player, under WVUHS sponsorship.

Why did it take so long, and why now? According to Michael King, CEO of the now consolidated and renamed Camden Clark Medical Center, "In years past, there was no "burning platform" to make a consolidation happen. Historically, both hospitals had experienced great success, knew that there would be a day that consolidation was necessary, but could never seem to overcome their different ownership and governance philosophies and structures.

"Recently, though, changing demographics, increasing pressure to manage the hospitals' cost structures, and the introduction of physician competition for diagnostic testing caught the platform on fire, and both hospitals began to decline," he says. "Once leaders of both hospitals realized the opportunity to stem the deteriorating situation required us to bury the hatchet, consolidation happened very quickly."

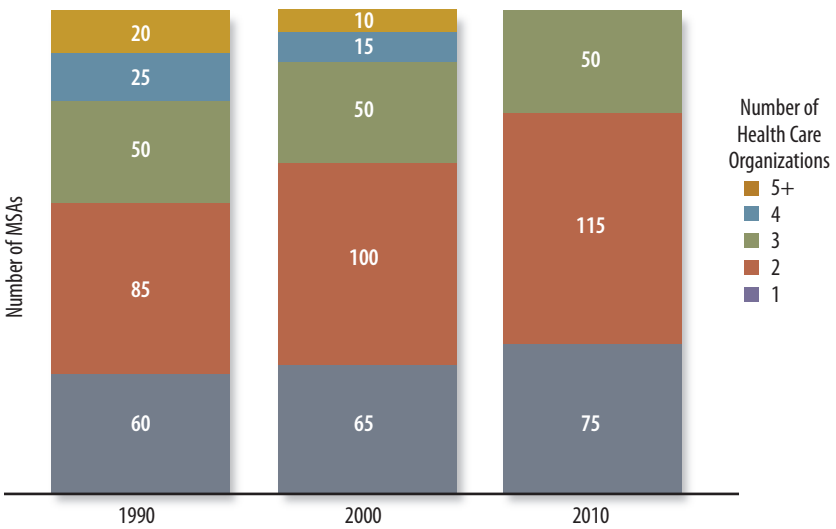
A History of 'Parkersburgs'

U.S. local and regional health care markets nationwide have experienced significant consolidation over the last 20 years. We believe this trend will continue to accelerate in the near term, creating many more "Parkersburgs" in the future.

We decided to examine the historical consolidation data to see what trends and patterns might appear. We studied data based on three snapshots in time—1990, 2000 and 2010—and looked at trends over the 20-year period.

We defined geographies by looking at metropolitan statistical areas with populations ranging from 50,000 to 1 million. This focused our inquiry on MSAs relatively comparable to Parkersburg's, which has an MSA population of 160,000. Our database resulted in a review of 240 MSAs, averaging about 200,000 people each and containing almost 17 percent of the U.S. population.

Increase in Metropolitan Statistical Areas with One or Two Health Care Organizations



Source: Navigant Consulting and Proskauer Rose, 2011

Defining how many health care organizations were in these smaller communities was a bit more nebulous. By health care organization, we mean both independent, freestanding local hospitals and multihospital health systems in a given MSA, that included only acute-care facilities with more than 50 beds. If the same organization owned more than one hospital in the same MSA, we counted it as a single entity.

As an example, let's look at the Lancaster, Pa., MSA. In 2010, Lancaster was home to four hospitals: two independent local hospitals and two hospitals owned by Health Management Associates, a publicly traded, Florida-based system. Because the two independent local hospitals are separately owned, we counted those as two organizations. In contrast, we counted the other two, both owned by HMA, as one entity. Thus, for our analysis, Lancaster is classified as a three-health care-organization town.

What did the data reveal? Forty percent of the 240 MSAs we studied had fewer organizations in 2010 than they had in 1990, primarily due to mergers and consolidations. Several dozen communities had two or three fewer organizations in 2010 than in 1990, such as Fort Myers, Fla. But the majority had one fewer health care entity. And, the number of two-organization towns increased vfrom 85 to 115. That's a lot of Parkersburgs.

Only a few of these small communities ended up with a greater number of organizations during that same period. It came as no surprise to us that those MSAs have experienced above-average population growth.

National health systems fueled this consolidation. In 2010, of the top 10 largest multihospital systems in our study, six were national for-profit systems, and three were large Catholic multihospital systems with operations spanning the United States.

Reform Advances Existing Forces

If history were the sole barometer for our prediction, we wouldn't feel as strongly about why there will be more

Parkersburgs in the future. So, here's the second argument: the Affordable Care Act of 2010 has accelerated existing market forces pressuring two- and three-HCO communities. And with health care reform evolving, those pressures are only intensifying.

For most Parkersburgs, the number of hospitals and staffed beds required to serve a given population was determined when times were different. Those decisions occurred when the population was growing, inpatient utilization rates were higher and reimbursement was increasing.

These trends largely have stopped and, in some cases, reversed. Population growth for many MSAs in our analysis is expected to be flat going forward. Reform provides incentives, through accountable care organizations, to providers for decreasing utilization for a given population. And future reimbursement faces a triple threat as Medicare, Medicaid and commercial payers all face their own new set of challenges given demographic, economic and regulatory developments. Collectively, these developments represent a new normal, and raise the question: Is the current delivery system in places like Parkersburg optimally configured given future population, utilization and reimbursement realities?

These factors also intersect with the more traditional consolidation drivers, such as economies of scale and access to capital, and raise another question: Will the new normal cause health care organizations in the same community to consider affiliating more aggressively in the future? There's a good chance the answer is yes. Because communitywide collaboration in a given market may be one of the only ways for many entities to recalibrate their delivery systems—physicians, care continuum, value proposition to payers—to sustain the challenges of a post-reform health care landscape and remain a quality resource for the community.

Of course, mergers are just one of many options for organizations in the same MSA looking to affiliate. There is a wide spectrum of structures available to organizations, ranging from loosely affiliated contract arrangements and joint ventures to tightly affiliated full-asset mergers.

But, we think mergers likely will be the vehicle of choice for rolling forward the next wave of Parkersburgs. Short of a merger, hospitals certainly can engage in collaborative, but discrete, trust-building ventures, but they are not going to be able to do the big things together that create significant long-term value, like joint planning and rationalization of services.

Many boards in two-hospital towns incorrectly assume that the antitrust laws close the door to full-scale mergers. In our experience, however, that is rarely the case. In the vast majority of instances, the pro-competitive effects of a merger are compelling and can be shown to more than offset the merger's potential anti-competitive effects. Also, the market impacted by the merger for purposes of the antitrust laws is rarely the borders of the two-hospital town. On the contrary, the much broader primary or secondary service area from which patients flow in and out may well be the antitrust-relevant market. Further, unless your local employers and payers strongly object to the merger, which is often a politically untenable position to take, there aren't victims about whom antitrust regulators will be concerned. And finally, many two-hospital towns include at least one governmental hospital, many of which may be antitrust-immune due to their governmental status as state actors.

In 2010, of the 750 health care organizations in the MSAs we studied, 105, or nearly 15 percent, are government-operated. The bottom line: Although the Obama administration's antitrust enforcers have begun to take a more active posture on hospital mergers, local boards should not avoid beginning meaningful merger discussions based solely on the unnecessarily cautious conclusion that, for antitrust purposes, a two-hospital merger will be dead on arrival.

That said, we recognize future consolidation will continue to take various forms. For example, another option is for two organizations in the same MSA to identify separate, out-of-town multihospital systems to join, perpetuating local competition but losing local control. Which is more important to the board and more vital to the mission?

A Study of Hospital Consolidation Data

TIMING

Three snapshots in time: 1990, 2000 and 2010

GEOGRAPHIES

Criteria: Metropolitan Statistical Areas between 50,000 and 1,000,000 residents; with fewer than 10 hospitals in 2010

Total MSAs assessed: 240

Total population of MSAs assessed as a percentage of total U.S. population
2000: 46 million (16%)
2010: 51 million (17%)

HEALTH CARE ORGANIZATIONS

Criteria: Includes independent hospitals and multihospital systems

Two or more hospitals owned by the same organization in the same MSA were counted as one entity

Total organizations assessed:
1990: 905
2000: 885
2010: 750

Sources: American Hospital Association Guides (1991, 2001, 2011), U.S. Census Bureau, Navigant Consulting and Proskauer Rose research and analysis.

Communitywide Quality

What's in it for the organization? Mergers are not easy to pull off and operationalize. In fact, they are very complex. But at some point, each of the Parkersburg-like communities of the last 20 years decided that the rewards outweighed the risks.

A key benefit of consolidation is the collaboration that arises from merging two or more entities in the same community. A "we" mindset is very different from an "us vs. them" mindset and oftentimes patients benefit when the preoccupation is not market share, but patient care. Some administrators who have worked through a merger in MSAs in our study have seen these benefits accrue.

"We were able to drive learning experiences through the community through consolidation," says James Nathan, CEO of Lee Memorial Health System in Fort Myers, Fla. "The conversation was no longer about upsetting physicians and worrying about who may take patients where. Instead, what we got was phenomenal support from physician leadership on clinical initiatives like patient safety."

Lee Memorial's story jumped out from our consolidation analysis. In 1990, Fort Myers had four different health care organizations, one of which was 540-bed Lee Memorial Hospital. By 2000, the MSA was served by two entities: two-hospital Lee Memorial Health System and HCA, the multibillion-dollar for-profit organization with three hospitals. Fast forward to 2010: Lee Memorial Health System, with three hospitals and more than 1,900 beds, is now essentially the sole community provider. HCA sold its hospitals to Lee Memorial and left the market. Today, there's only one other organization in town, a smaller hospital owned by HMA.

For Fort Myers, the "we" mentality continues to add value today, through a more regional approach to addressing the community's health.

"Access to comprehensive and coordinated behavioral health services has been a serious problem in our community," Nathan says. "By not spending our time on traditional competitive issues, we were able to bring a large number of community stakeholders together to develop a community-health game plan focused on behavioral health. A behavioral health triage center was established, access points were increased, and we recently had a groundbreaker for a new psychiatric hospital. I'm not sure that would've been possible before.

> 'The conversation was no longer about upsetting physicians and worrying about who may take patients where.' — James Nathan, CEO of Lee Memorial Health System in Fort Myers, Fla.

Mergers can create opportunities for standardizing quality across the community as well. "We have the best relationship we've ever had with emergency medical services as we share a communitywide emergency triage center," he says. "Now we have common medical bylaws throughout the community, common credentialing, common quality agendas. We're improving overall clinical efficiency and have reduced operating costs, charges and supply expenses for our community through clinical specialization and standardization across clinical programs such as orthopedics."

Cost savings and access to capital are additional benefits and among the most obvious. Reduced costs typically occur in the form of favorable pricing for suppliers, increased negotiating power with health plans, and reduced administrative redundancy in such areas as finance, marketing and legal. Over time, these cost savings should help to offset revenue pressures. Additionally, mergers can provide health care organizations with substantial capital for information technology, clinical integration, performance improvement initiatives and facility modernization.

Back in Parkersburg, "these two hospitals are a quarter of a mile apart and already shared 85 percent overlap in the medical staff, says Camden Clark CEO King. "One has an average daily census of 175, the other 80. We immediately merged the board and medical staffs. The biggest financial opportunity in the first 60 days was creating a unified management structure and consolidating laboratory operations. We eliminated $3 million in duplicative upper and middle management salaries and saved approximately $1 million in the lab.

"A significant initial nonfinancial opportunity was created in selling a new vision of the future hospital to the community … something they readily embraced," King adds. "We have now turned our attention to program consolidation, focusing initially on consolidating obstetrical services. We think, conservatively, that there are millions of dollars on the table in duplicative functions and services.

What the Future Holds

Trustees who always have wondered what it might be like if the two health care organizations in town decided to merge soon may witness the change. Reform has accelerated the shift toward value-based care, fueling consolidation and increasing the chances history repeats itself. Merging is complex and comes with obstacles, but when done right can provide significant community, strategic, financial and clinical benefits. Nobody knows for sure, but we think two-hospital town boards should be looking to Parkersburg as a harbinger of their futures. **T**

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