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HealthLeaders

Hitting the Landing Zone

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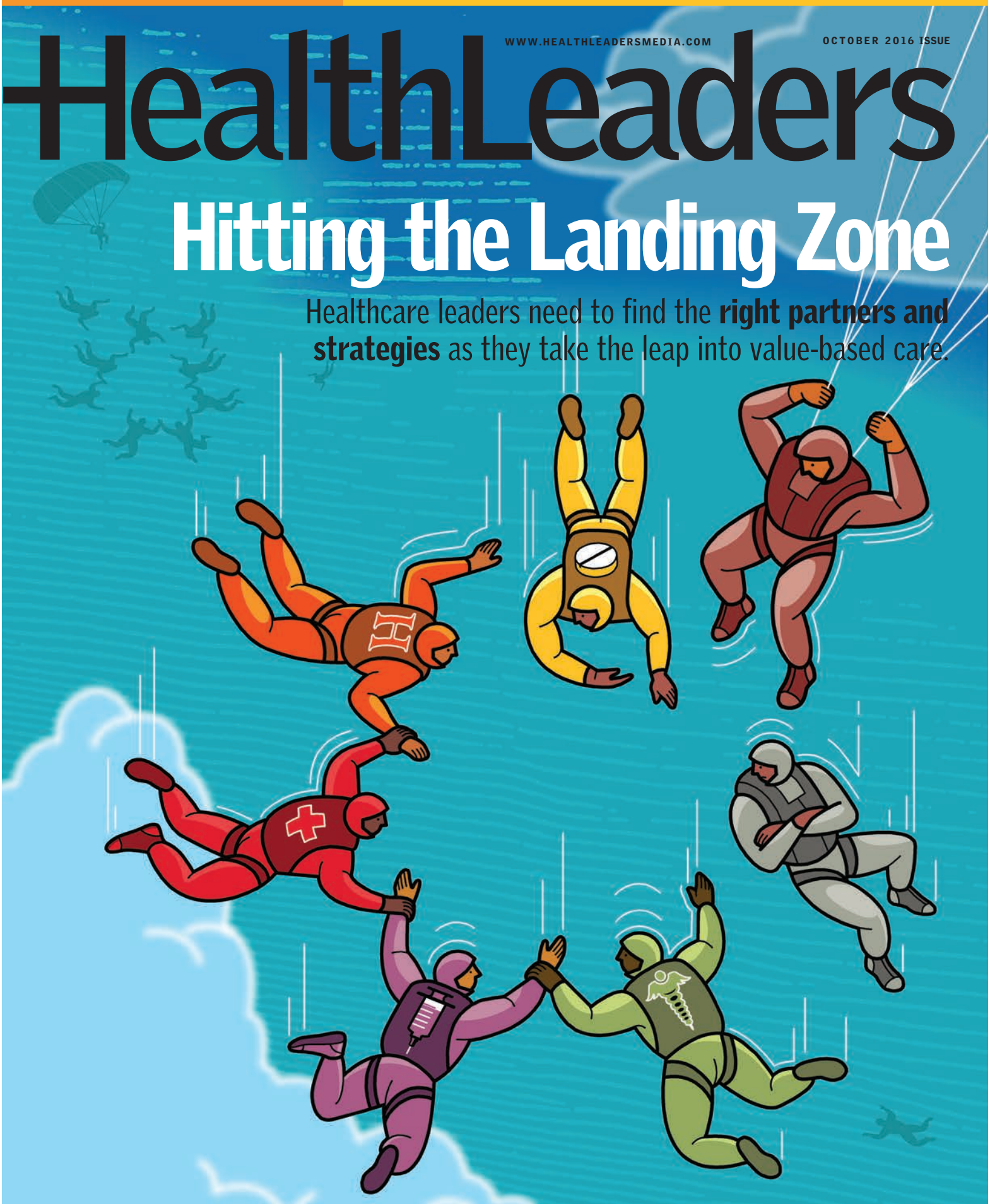

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—John N. Kastanis, CEO, University Hospital in Newark, New Jersey

COVER STORY

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By John Commins

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COVER STORY

HITTING THE LANDING ZONE

Healthcare leaders need to find the **right partners and strategies** as they take the leap into value-based care.

BY JOHN COMMINS

Hospital consolidations have become a weekly event across the United States, and the pace and scope of these consolidations is getting faster and bigger. In 2015, the number of hospital transactions increased to 112, up 18% over 2014's 95 deals, which, according to a study from consultants Kaufman, Hall & Associates, LLC, includes mergers, acquisitions, joint ventures, and joint operating agreements. Such activity is more than 70% greater than the 2010 level of 66 deals.

Hospital leaders say these consolidations are driven by a big push from the Patient Protection and Affordable Care Act and commercial payers toward population health and risk-bearing, value-based care, which require economies of scale.

"When the ACA said you had to have an electronic health record and the ACA expects everyone to move to population health, that doesn't come cheap," says Christopher G. Dawes, president and CEO of Lucile Packard Children's Hospital Stanford and Stanford Children's Health in Palo Alto, California. "You have to buy these very sophisticated computer systems. We are a moderately sized hospital, and we purchased an electronic health record system that cost us more than $110 million, with the acquisition price and training. That is obviously a lot of money."

Creating the infrastructure to provide population health is also labor intensive.

"That is dozens and dozens of people who are focused on population management, doing the analytics, and involved with sales and managing activities and managing utilization," Dawes says. "If you are going to get into population management, you can't do that as a small player. You don't have the critical mass to make the math work. The pediatric and adult world are being pushed into larger entities, and they need to get some value out of the scale."

Even as the pace of hospital consolidations is accelerating, the process is evolving, and that means hospital leaders must adapt.

What's the Endgame for Consolidation?

Despite the accelerating rate of hospital consolidations in the past five years, the sector remains largely decentralized. There are roughly 5,600 hospitals across the United States, including more than 4,900 community hospitals. Still, it's not clear if this consolidation movement will continue apace, taper off, or even reverse itself. We asked these hospital executives and observers how they expect consolidation will evolve over the next decade.

Michael D. Williams

Founding president and CEO, Community Hospital Corporation, Plano, Texas

"The hospital landscape will be reflective of the payer landscape. The further down the continuum we go toward a single-payer system, the more likely there will be fewer hospital providers of care. The proliferation of some consolidations has been motivated by organizations that are trying to serve a particular segment of the population. Consequently, if I can acquire a hospital that is in a geographic market with more commercial insurance than Medicare/Medicaid insured, I am going to have greater profitability. If we ever move toward a single-payer system where all rates were more universally equal, the motivation to consolidate for geographic benefit or payer benefit would be diminished. That's for the provision of 'sick care.'

"The bigger question is, what will be the role of the smaller community institutions, the 200- to 300-bed stand-alone hospitals? Are they going to be contracted as just a commodity with the mega-population health models? Are they going to continue to be contracted with the population health model just for fee-for-service, so they are going to be a commodity, or will there be an opportunity for them to participate in providing not only improved outcomes and wellness, but a piece of the financial success that the larger organization enjoys?"

Robert A. Marino

Chairman and CEO of Horizon Blue Cross Blue Shield of New Jersey, Newark, New Jersey

"My vision for what the landscape would look like in the next five to 10 years is that we move from this unsustainable fee-for-service, inherently inefficient, costly system to a delivery and financing system that truly is going to reward value creation. Value creation has three components. The first is demonstrable improvement in the quality of care and the outcomes of care. The second is more engaged patients in the delivery of their care—engaged in terms of actually understanding their illnesses, working proactively with their physician and provider partners, higher emphasis on preventive care, and higher emphasis on wellness. And thirdly, if we are able to accomplish one and two, hopefully, we will be able to lower the cost of healthcare because the current system is not sustainable. The only way we are going to be able to get our arms around this year-over-year cost increase in healthcare is to change the paradigm."

John N. Kastanis

President and CEO of University Hospital, Newark, New Jersey

"State by state, region by region, you are just going to have a handful of integrated health systems. With that, you are also going to have just a handful of insurance plans. The larger integrated health systems will venture into their own insurance plans. What used to be North Shore-Long Island Jewish, now called Northwell, they are a more recent example of how their growth and integration has afforded them the opportunity to develop their own insurance plan and sell that to the communities they serve. People in their service area have seen something like Northwell develop into such a powerful and effective

"Historically there were two kinds of mergers and acquisitions," says Michael D. Williams, founding president and CEO of Plano, Texas–based Community Hospital Corporation. "It was the investor-owned sector looking for those hospitals that had been poorly managed, that they could gain low-hanging fruit in a short period of time. It was acquisition for the purpose of growing the revenue stream and the bottom line.

"On the not-for-profit side," he says, "it was that spoke-and-hub mindset of 'If we can go out and acquire enough of the surrounding smaller hospitals, we can get a greater percentage of the referrals and we are the tertiary center, we can be more successful.' "

What has changed, Williams says, is that both the investor-owned and not-for-profit sectors have become more selective about the hospitals they're acquiring.

"They are looking for the already high-performing hospitals that can be acquired to complement their own portfolio," he says. "The not-for-profit sector organizations are saying, 'No longer can we afford to go out and acquire smaller hospitals or community-based midsize institutions and accept the liability associated with their bottom line. We have to be creative in determining new types of relationships that will bring us what we need and want, but without accepting that liability.' "

Examining the options

University Hospital in downtown Newark, New Jersey, exemplifies many of the challenges threatening the survival of stand-alone hospitals in an evolving healthcare delivery landscape.

The money-losing, state-owned, 325-staffed-bed academic medical center serving some of the city's poorest neighborhoods controls about 14% of an over-bedded five-hospital market that since 1999 has seen six hospitals close.

A 2015 state-commissioned report found significant duplication of services in a Newark regional market that

integrated system that they will buy their insurance plans."

Christopher G. Dawes

President and CEO, Lucile Packard Children's Hospital Stanford and Stanford Children's Health, Palo Alto, California

"Sadly, there will be fewer freestanding pediatric hospitals than there are today because some of the smaller players will become part of either another children's hospital or one of these larger systems. I say 'sadly' because there are only about 200 children's programs and about 40 or 50 children's hospitals, and they train almost 50% of pediatricians in this country. They also lead the pediatric research that occurs in academic medical centers.

"It is critical that children's hospitals continue to exist, particularly some of the larger ones, and that we continue to focus on pediatric research and training pediatricians for the future. That's what concerns me as a children's health executive, that over time that will be an increasing challenge for us. There will be fewer children's hospitals, but the larger ones will get larger and we will be able to continue to carry that water in terms of the training and research. Also, we have a rapidly aging population. So we are going to see less and less money flowing to kids' healthcare."

Michael T. Rowan

President of health system delivery and chief operating officer at Catholic Health Initiatives, Englewood, Colorado

"I don't know for sure how it will turn out. I say that because across the country markets are still so very different and there are such different places along an evolutionary path. We have in this country some markets where there is very little consolidation. There are few large physician groups, versus other markets where every provider is in a large independent group or employed by a hospital. You can go to some markets where you're hard-pressed to find doctors' offices that have more than five doctors. There are markets where the payer side is highly consolidated, where one payer has 80% of the market. And in other markets no payer has more than 30% of the market. It is so different that it's hard to think that we are going to evolve to this idea that there are five or six systems out there across the country, whether they compete with each other or not."

"In five or 10 years we'll see a handful of **regional super-systems."**

Glenn A. Melnick, PhD

Blue Cross of California chair of health care finance at the University of Southern California in Los Angeles and a RAND health economist in Santa Monica, California

"In five or 10 years we'll see a handful of regional super-systems. My studies have shown that by getting together you can charge $4,000 more per admission. Why wouldn't you join that club? Sutter Health has a very interesting affiliate model. These hospitals still have a lot of independence, and it's not a highly integrated model. The difficulty is they aren't really centralized, certainly the nonprofits. You can't really develop these centralized systems for efficiencies that you roll across everybody if the affiliate members have a lot of independence. But I think it's the wave of the future. It is going to be pushed by this ACO concept. The ACOs are basically going to be these giant capitated plans that cover everything. So the big hospital systems are going to buy medical groups in the hopes that they can control the doctors. It remains to be seen whether that is going to work or not. If they become a large enough employer, they can threaten to fire doctors who use too many services."

John Commins is senior editor for HealthLeaders Media. He may be contacted at jcommins@healthleadersmedia.com.

serves 670,000 people. The report noted that UH and the four other hospitals lost a combined $32 million in 2013 and would lose $190 million by 2019, excluding a state charity care subsidy, under an unsustainable status quo. As the state moves toward a population health model, the report said, action is needed to reduce the number of inpatient beds, consolidate specialty care in certain hospitals, and better coordinate outpatient and primary care.

This is the challenge that John N. Kastanis accepted when he took over as CEO at UH in March 2016. A turnaround specialist, Kastanis was lauded for his leadership at Temple University Hospital in Philadelphia, where, in less than five years, he stanched the red ink at the 722-bed academic medical center and improved quality rankings.

While he expects to face many of the same challenges at UH in the coming months, Kastanis says he doesn't expect a cookie-cutter response as the hospital considers its affiliation options. "You've heard the adage: When you've seen one academic medical center, you've seen one academic medical center. We're all unalike. We all have our separate histories, different traditions, and the cultures vary."

The common factor at Temple University Hospital and Newark's University Hospital is a committed medical staff that understands the link between margin and mission, and is willing to adapt to new care models, he says.

"When you have a solid core of medical staff who remain dedicated and committed to the hospital where they are affiliated, you still have potential," Kastanis says. "The medical staff are very excited about the new leadership of the hospital. They all have great ideas about expanding their existing respective clinical programs and adding new ones. That was one of the main reasons I took the job."

Another reason why Kastanis took the job was to develop a population health collaborative—called for by the state report—with Rutgers Health and the newly merged, 11-hospital RWJBarnabas Health.

"I'm excited about the chance to work from a regional strategic plan that improves on the delivery of care on all levels, not just the tertiary and quaternary care that UH provides," Kastanis says, "but also at the primary care level and preventive level and reaching out into the community and aligning ourselves better with each other and with other

>THE COMMITMENT FACTOR. John N. Kastanis is CEO at University Hospital in downtown Newark, New Jersey. He says that medical staff who are dedicated and committed to their hospital and excited about hospital leadership are energized to think of great ideas to expand respective clinical programs and to add new ones.

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providers, whether it is the federally qualified health centers or other community-based providers."

One key challenge will be determining where to provide care and where to trim inpatient services in a region that is over-bedded. Another problem is money.

"We want to continue to promote academic medicine at University Hospital, but where do you find the financial resources to make this happen?" Kastanis says. "Also, we need the capital to keep pace with all the new technological advances, and we are going to need significant dollars to upgrade and possibly replace our facilities. That is all going to come from collaborations and partnerships. It gets a little tricky with us being a public, state-owned hospital. There are ways to do it, perhaps a public-private partnership, but those models are out there and they can be replicated."

"We need the capital to keep pace with all the new technological advances, and we are going to need significant dollars to upgrade and possibly replace our facilities. That is all going to come from collaborations and partnerships."

As UH builds affiliations with Rutgers Health, RWJBarnabas Health, and other providers in the region, Kastanis says the academic medical center cannot afford to lose focus on improvement.

"This can be achieved, for example, by combining existing high-acute and specialty services at other hospitals with University Hospital, while possibly repurposing the new affiliate hospitals into ambulatory sites. Also, current New Jersey assets and liabilities (e.g., facilities, property, pension plans) can be retained by the state while University Hospital is managed by a private corporation, allowing for more versatility in management, planning, and financing, and functioning more effectively in an ever-evolving competitive healthcare marketplace," he says.

"We have to be a lot more efficient in the way we provide care, even at the high-acute, tertiary, quaternary levels," he says. "That's high cost, but we have to learn, being an academic medical center, to be that much more cost efficient. That is a big challenge. I did it at Temple in a pretty successful way, and I plan to do it here. I have medical staff who are willing to see what they can do to change their practice patterns, to redesign and try to be more efficient in patient throughput at the academic level."

Physician integration is inherent in hospital partnerships and affiliations to achieve clinical efficiencies. After Rutgers Health launched in April 2016 the faculty committed to a transformation process that included best practice reviews, redesign, and new, value-based clinical pathways.

Creating different models for physician integration should also be in the mix when collaborating with physicians. At Temple University Health System, for example, Kastanis says community-based physicians were hired part-time and full-time to cover off-site ambulatory care facilities and medical homes through a separate corporate enterprise called Temple Physicians Incorporated.

Finding the right fit

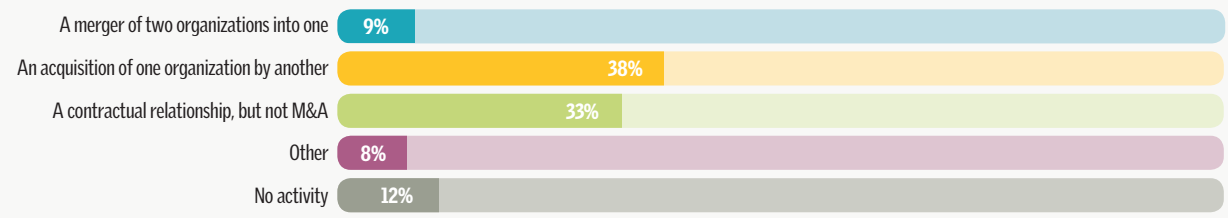
For many stand-alone or independent hospitals, a common way to adapt to population health and value-based care and to enjoy virtually instant economies of scale is to merge into a larger health system.

CHC's Williams says smaller, midsize, and community hospitals looking for the right partner or partners must first understand out-migration to learn where their patients are being referred by the physicians who practice at the hospital.

"If those referrals are to multiple sites for cancer, cardiac work, etc., yes, the relational iterations of specialization could create an organization with more than one partner," he says. "But it has to be based upon the medical staff

MOST RECENT MERGER, ACQUISITION, AND PARTNERSHIP ACTIVITY

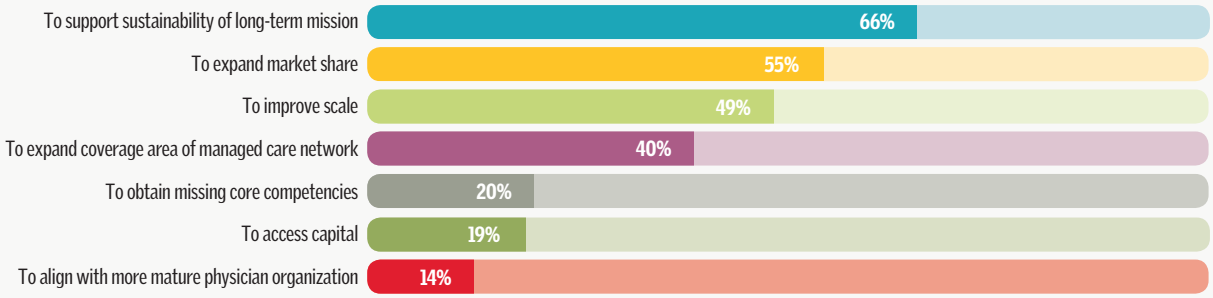
Please describe the nature of your most recent merger, acquisition, and/or partnership activity.



Source: HealthLeaders Media Intelligence Report: *Strategic Partnerships: Survival in Healthcare*, April 2016; http://bit.ly/2cjdshX.

REASONS FOR CONSIDERING A MERGER, ACQUISITION, OR PARTNERSHIP

If you have considered/are considering a merger, acquisition, or partnership with another organization, what were/are the main reason(s)?



Multi-response

Source: HealthLeaders Media Intelligence Report: *Strategic Partnerships: Survival in Healthcare*, April 2016; http://bit.ly/2cjdshX.

relationships—historically and where they are going to be going in the future."

Smaller hospitals that want to merge with larger systems must remove emotion from the process, Williams says, and focus on optimizing the bottom line.

"Before anything happens, before you put yourself on the market for any type of relationship, you have to be assured that you are optimally performing," he says. "When you sell, it's going to be a multiple of your cash flow or EBIDTA. If you have multiple organizations competing for you, you want to be optimally performing so that when they look at you they want to include you in their population health provider base. All of that has got to be fact-based."

Once the financial assessment is completed, the smaller hospital has to determine what it needs from a merger. Williams riffs on a handful of questions that hospital leaders should ask themselves: "Do you need clinical collaboration, and if so in what areas? Do you need managed care clout and negotiation clout in working with the major payers based on what you think your reimbursement might be? Do you need access to medical staff, for either rotational or a full-time presence in your community? Do you need continuing education for your team? What do you need and who can provide that within the organizations that are looking to acquire or create some relationship with you?"

Increasingly in the not-for-profit sector, larger organizations are less inclined to acquire smaller hospitals, and instead are more interested in clinical collaborations and physician recruiting.

"We have one client for whom the tertiary center was able to provide a group of cardiologists who were willing to come to the community and staff an outpatient center," Williams says. "The presence of those cardiologists in that market has been a significant financial benefit to that local hospital. But that larger institution saw a great opportunity to grow their cardiac business if in fact they did something differently."

Doing it "differently" meant that the larger institution saw the opportunity to partner with the cardiology group to enhance the continuum of care rather than compete with it in the secondary market. An integrated IT infrastructure between the two organizations also enhanced the relationship, says Williams.

Developing a modified hub-and-spoke model

The traditional brick-and-mortar acquisitions are still occurring, but, increasingly, the more-nimble affiliation models are fulfilling the same objectives without limiting opportunities to collaborate with several providers on a broader array of services.

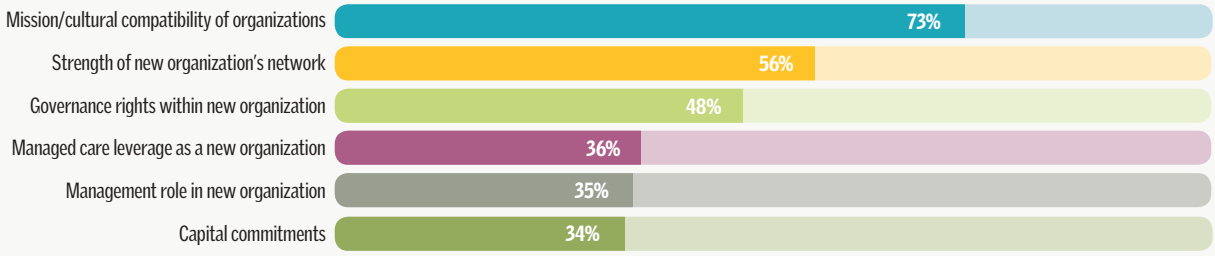
Dawes says the Stanford Children's population health model provides excellent opportunities to expand its pediatric specialty and OB-GYN footprint in the Bay Area. "If your hospital doesn't have a strong pediatric program, how do you move into this population health management arena, which is driving a lot of these consolidations and partnerships? How do you do that to attract young families, the part of the population you want to serve?" he says.

> **"It takes a lot of energy and time.** One could argue that it is easier to acquire. But from our viewpoint, our ability to JV with multiple parties allows us to access a much bigger market."

Stanford Children's has joint ventures with five adult acute care hospitals in the Bay Area, using a variation on the

IMPORTANT CONSIDERATIONS FOR A MERGER, ACQUISITION, OR PARTNERSHIP

What considerations are most important to your organization when considering a merger, acquisition, or partnership?



Multi-response

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hub-and-spoke model. "We are the central hub, but the difference is the spokes have little hubs on the ends," he says. "We reach out to a place like John Muir Medical Center, for example, and they become a hub for the local community, and the more complex stuff comes back to the central hub, which is us." The John Muir facility is about 50 miles north of Palo Alto in Walnut Creek, California.

"If your hospital doesn't have a strong pediatric program, how do you move into this population health management arena, which is driving a lot of these consolidations and partnerships? How do you do that to attract young families, the part of the population you want to serve?"

The widespread shortage of pediatric specialists in virtually all parts of the United States also furthers the drive to affiliate with children's hospitals. "Because of that we are seeing, in certain cases, partnerships are being formed with major children's hospitals to get the access to pediatric expertise so you can manage the population of pediatric patients," Dawes says.

He describes Stanford Children's as "a freestanding children's hospital that is accessing the ACO world with our partnership with our sister hospital Stanford Healthcare, but also partnerships with others around the Bay Area.

"In other areas, you're seeing children's hospitals, such as ours, who are seeking partners because we want to be able to play in the ACO world, and in order to do that we need access to adults as well," he says. "So, both sides are motivated in that regard."

The key to success with any joint venture, Dawes says, is that the deal has to benefit everyone. "The host hospital gets the value of first-class pediatric care. They don't have to pay for it directly because it's part of the JV, but they get first-class pediatric care in their communities so they can attract patients to their hospitals. Keep in mind that women make most of the key healthcare decisions in a family, and the first experience that a young family has with a hospital is typically the birth of their first child. This is a way for these entities to attract young families."

These affiliations also require a common set of values and a strong sense of trust between executive and clinical leaders, and a strong governing and operations structure that sets priorities and metrics. "Lastly, we have to deliver pediatricians and pediatric specialists to these hospitals so we can fulfill our commitment," Dawes says.

Dawes describes the JVs that Stanford enters into with other hospitals as a hybrid that attempts to garner all the advantages of a traditional merger while maintaining the autonomy of each hospital. It is stronger than a mere referral network because Stanford specialists work in these JV hospitals with their employed or affiliate physicians to coordinate care, as opposed to merely accepting referrals.

The JVs give Stanford Children's access to nearby markets without having to buy them. "We create a partnership, and now we are in a community and we can serve that community," Dawes says. "We attract less-acute patients to their local host hospital, and the high-end cases come to us. It gives us greater market share in these communities. It remains local, but in some cases the business comes to us. And it's been very effective and been the impetus for us to substantially increase our market share in the Bay Area."

While the rewards are enticing, Dawes says the process is difficult. "It takes a lot of energy and time," he says. "One


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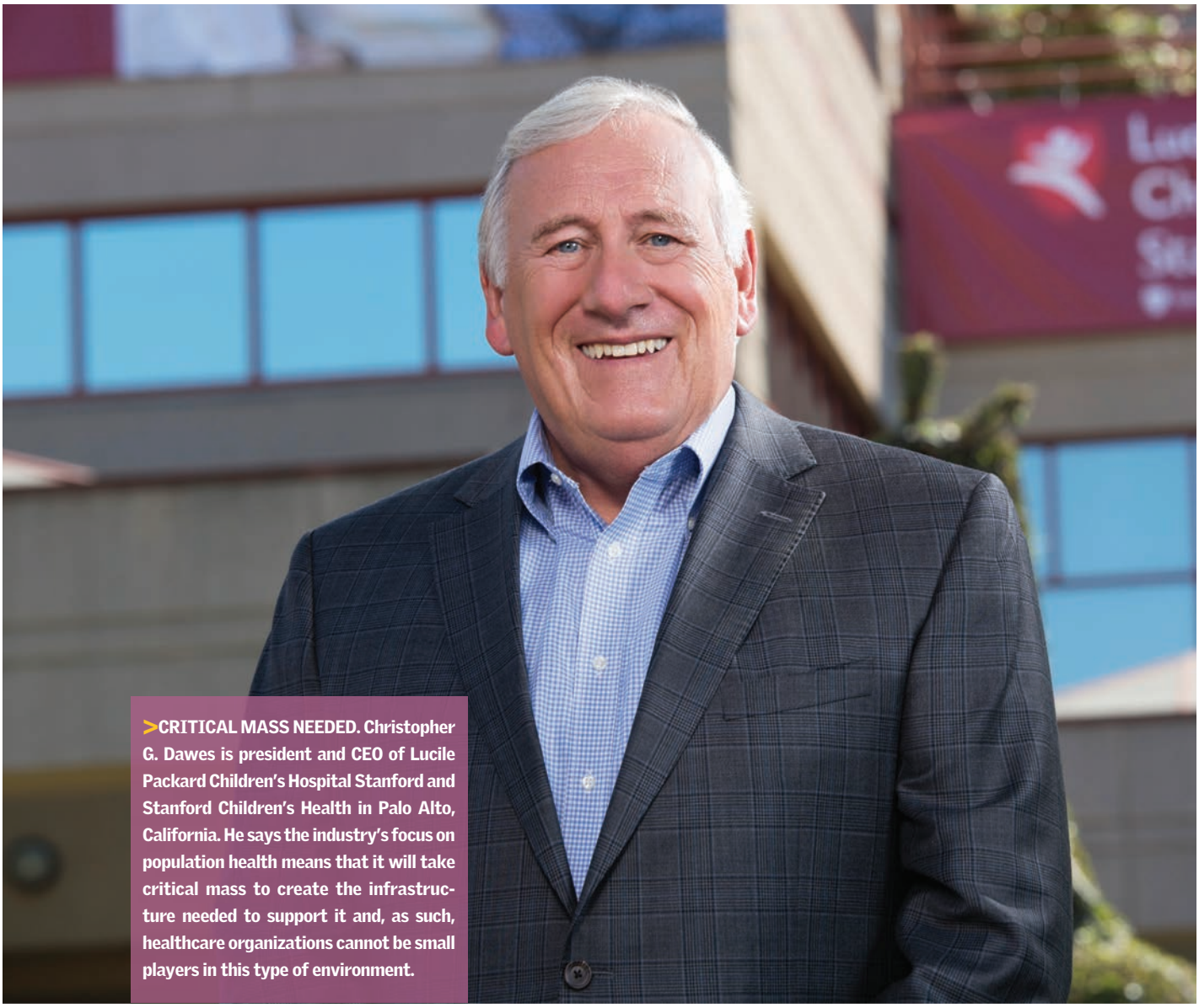

>CRITICAL MASS NEEDED. Christopher G. Dawes is president and CEO of Lucile Packard Children's Hospital Stanford and Stanford Children's Health in Palo Alto, California. He says the industry's focus on population health means that it will take critical mass to create the infrastructure needed to support it and, as such, healthcare organizations cannot be small players in this type of environment.

LUCILE PACKARD CHILDREN'S HOSPITAL/STANFORD CHILDREN'S HEALTH

could argue that it is easier to acquire. But from our viewpoint, our ability to JV with multiple parties allows us to access a much bigger market."

Evolving payer models

As the provider side consolidates, so too has the payer side, which has led to a chicken-or-egg argument about who's responsible for all this merger, acquisition, and alignment activity.

Michael T. Rowan, president of health system delivery and chief operating officer at Englewood, Colorado–based Catholic Health Initiatives, says it's been interesting to watch how payers evolve.

"If you look at some of the payers, there are three things that historically they do," Rowan says. "One, they put together a network of providers, so you start to get larger health systems and they have a natural network of providers. Two, the payers historically have managed benefits. Larger and more sophisticated organizations may be keen to do some of that for themselves. Three, they put together various products to sell out there, and more and more if you have an integrated delivery network you can begin to put together a product which includes long-term care, ambulatory care, diagnostic services, and inpatient care and home care and primary care and the like.

"So, you can begin to start to see some of the friction because some of the things that historically the payers have done, larger and more sophisticated integrated networks are capable of doing that now," Rowan says.

Dawes at Stanford Children's says payers' enthusiasm for provider consolidation swings both ways. "Sometimes payers encourage it because they are focused on building networks," he says. "Other times payers are less enthusiastic because we are a high-end place and it gives us access to more markets, which means it gives us more leverage as well. Overall, the payers certainly haven't responded negatively."

Robert A. Marino, chairman and CEO of Horizon Blue Cross Blue Shield of New Jersey, says payers are simply adapting to the new market created by the ACA's push for population health, and the consequent consolidation of provider networks. While leverage was once a key motivator for providers and payers, Marino says other factors are coming to the fore.

"If you were to ask me three years ago, I would have said the main motivator for provider consolidation is market share and leverage with payers," he says. "But, over the past three years as this value-based movement has gained traction, there are hospitals and health systems out there that are trying to consolidate to create greater value in terms of acquiring a full continuum of healthcare access for inpatients/outpatients, doctors' offices, and freestanding facilities, as well as positioning themselves to be able to move toward value-based payments.

"Many of these systems that have consolidated in New Jersey are working with us to move toward population management with the ultimate goal of accepting risk for managing a population of patients and keeping them healthy," he says. "The proof for me as I see hospital consolidations in our market has been the fact that those systems that have consolidated are truly motivated toward moving to a value-based system."

In fall 2015, Horizon launched a preferred provider network in New Jersey called OMNIA Health Alliance that includes six of the largest hospital systems and one large multispecialty practice group.

"It's an innovative approach that changes the historical relationship between the payer and provider from one that was based on an annual fight over rates, to a longer-term view of how do we move this system toward a value-based system in which the focus will be on population management, keeping patients well, keeping patients out of the hospital, engaging the patients in their care, engaging them in preventive care, and lastly the ability of all of that to lower the total cost of care," Marino says. "Another aspect of what we believe is very innovative about this partnership is that over a period of time these providers will actually assume financial risk for the well-being of their populations that are assigned to them."

For OMNIA's partner providers, Marino says Horizon provides a pathway to full capitated risk that begins with shared savings, transitions to risk corridors after two years, and then transitions to full global capitated risk several years after that.

Marino describes OMNIA as a tiered network, "not a narrow network."

"We took our largest managed care network, and we created tiers within that network. This was done in response to a tremendous amount of research the company has done over the past several years, where our customers have told us that healthcare costs in New Jersey are unaffordable and they were looking for a lower-cost quality options," he says.

Horizon customers who select an OMNIA product will see an average premium reduction of 15%. "If they choose to do that, they will see little, if any … out-of-pocket costs in terms of even a deductible or coinsurance," Marino says. "If they use a provider in the broader network of what we classify as Tier Two, they will have out-of-pocket costs that are very similar to the out-of-pocket costs they pay today."

Since its launch in late 2015, more than 235,000 of Horizon's 3.8 million members have joined OMNIA. "When you look at these 235,000 members, 175,000 of them are individual consumers who write a check every month to pay for their healthcare," Marino says. "That is the market that has been crushed by healthcare costs and 41,000 of those 175,000 individual consumers were previously uninsured in the state of New Jersey."

Hospitals that were invited to join Tier One had to meet key metrics. "Obviously, quality was important, as was their history and ability to demonstrate past performance in value-based care, the scope of services offered, the ability and readiness of the hospital systems to accept risk," Marino says.

Do Consolidations Promote Value or Leverage?

As hospital mergers, acquisitions, and affiliations occur more often across the nation, a growing number of studies is linking these consolidations with higher downstream healthcare costs for payers, employers, and consumers.

That shouldn't be terribly surprising. Until recently, it was not uncommon for hospital executives announcing consolidations to boast that their larger health system would use its enhanced market power to "leverage" higher payments from payers.

Those boasts have been muted of late as the Federal Trade Commission, researchers, public interest groups, and the healthcare news media have begun to look at the effects of hospital consolidation. The argument has shifted, and the claim now is that larger systems are needed to account for population health mandates, and that these consolidations will pay for themselves by delivering value-based care and improving quality.

Is that a valid claim or a fig leaf? Many critics remain unconvinced.

FTC Chairwoman Edith Ramirez, speaking May 12 at the American Bar Association's Antitrust Healthcare Conference in Arlington, Virginia, said that most providers cannot demonstrate that consolidations promote efficiency and value.

"We devote considerable time and resources to evaluating efficiency claims, especially those that are quality-related. Parties, however, have largely failed to present us with even a close case [on efficiencies], often providing little substance to back up their claims," she said.

Ramirez said regulators are also unconvinced that a merger is required to provide the patient volume needed for risk-based population health management. "We recognize that healthcare is increasingly moving in this direction, and [we] continue to assess, on a case-by-case basis, whether a merger that enables parties to engage in these and other activities could benefit consumers," Ramirez told the conference. "Yet there is strong evidence that scale, at least over a certain threshold, is not necessary to engage in those practices. Greater scale can also be achieved through another combination that is not a merger with a close rival."

Glenn A. Melnick, PhD, Blue Cross of California chair of health care finance at the University of Southern California in Los Angeles and a RAND health economist in Santa Monica, California, says he too remains "appropriately skeptical."

"Achieving cost savings is not easy," he says. "My experience is that if providers can get together and leverage higher prices, that is what they do first and then they very quickly realize that 'the other stuff is a lot harder. Why do we have to do it?' "

"I am skeptical that these consolidations are going to ultimately result in price savings for consumers for two reasons," Melnick says. "One is if they lead to higher market share it's going to lead to higher prices. Even if they do achieve savings why are they going to pass them on? If these consolidations do increase market power, we are going to be stuck with higher prices regardless of any efficiency improvements in the system.

"Secondly, efficiency improvements are hard," he says. "The only reason they improve efficiencies is to lower prices to do better in a competitive market. If the market doesn't force them to lower their prices, they aren't going to stay up at night worrying how to do it more efficiently."

John N. Kastanis, president and CEO of University Hospital in Newark, New Jersey, says enhanced market share remains the main motivator behind consolidation.

"To be honest, it's more about leverage," he says.

In fact, Kastanis warns that quality and value can deteriorate if consolidations aren't properly orchestrated and managed. "A lot of these integrated systems, just because of scale—of growing and integrating at the pace they are—some are growing a little too fast," he says. "When that happens, quality suffers, clinical efficiency suffers. You have to keep a close eye on the rapidly growing health systems, especially ones that are crossing state lines and acquiring other hospitals."

> **"If these consolidations** do increase market power, we are going to be stuck with higher prices regardless of any efficiency improvements in the system."

Oddly enough, one of the strongest supporters of the idea that hospital consolidations can create value is a payer: Robert A. Marino, chairman and CEO of Horizon Blue Cross Blue Shield of New Jersey in Newark, New Jersey.

"In New Jersey the motivation has been about expanding the continuum of care in a given healthcare system, from inpatients through the whole continuum of hospital services. That is

the system's desire to move itself toward population management," Marino says. "Many of these systems that have consolidated in New Jersey are working with us to move toward population management with the ultimate goal of accepting risk for managing a population of patients and keeping them healthy. The proof for me, as I see hospital consolidations in our market, has been the fact that those systems that have consolidated are truly motivated toward moving to a value-based system."

Michael D. Williams, founding president and CEO of Plano, Texas–based Community Hospital Corporation, says the value model can work only under the right circumstances.

"History would tell us that there needs to be a consolidated governance structure with a consolidated management structure, and supportive medical staff saying that the rationalization of services on multiple campuses will be X, Y, or Z," he says. "Absent those indicators, more often than not these consolidations have resulted in higher cost rather than greater efficiency."

Michael T. Rowan, president of health system delivery and chief operating officer at Englewood, Colorado–based Catholic Health Initiatives, says "neither side is right" in the value versus leverage argument.

"On the one hand there is no doubt that economies of scale are available," he says. "CHI put together four organizations 20 years ago to create one of the first national health systems, and we have clearly been able to reap economies of scale with some basic things such as supply purchasing. We can still centralize certain activities, and we can afford a more sophisticated level of talent in the organization.

"On the other hand, when systems consolidate to amass certain strengths moving toward monopoly so they can negotiate for higher prices, in some cases, that is true," Rowan says. "The way the industry is set up, though, I am not sure that anybody is in a position to really negotiate, especially when you recognize that upwards of 60% of healthcare payments are from state and federal government, and for the most part those aren't negotiated."

In addition, Rowan says being a larger organization doesn't necessarily provide an ability to negotiate higher rates with commercial payers. "If you have a larger organization that has more sophisticated talent, it can sometimes produce a better product and you can get a better payment for that better product," he says. "It's more about that than it is amassing market share and squeezing payers."

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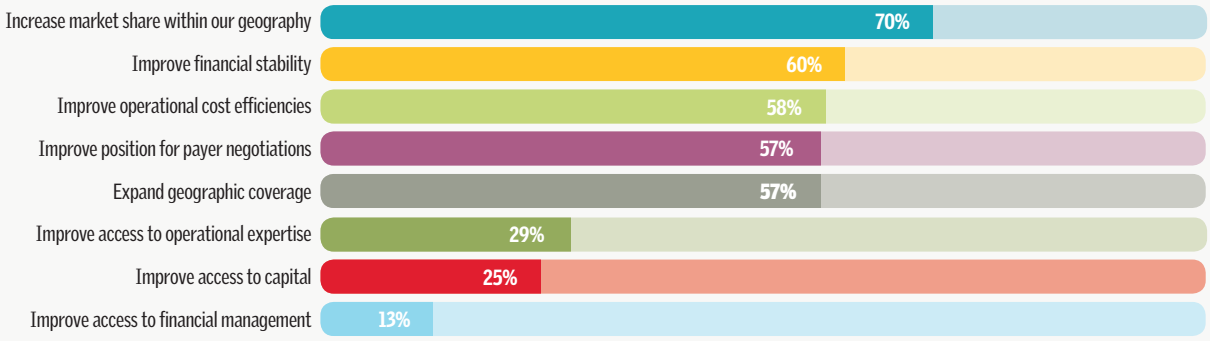
FINANCIAL OBJECTIVES OF MERGERS, ACQUISITIONS, AND PARTNERSHIPS

Which of the following are among the financial objectives of your overall merger, acquisition, and/or partnership planning or activity?



Multi-response

Source: HealthLeaders Media Intelligence Report: *Strategic Partnerships: Survival in Healthcare*, April 2016; http://bit.ly/2cjdshX.

When OMNIA launched, hospitals that were not in Tier One complained that they were placed at a competitive disadvantage with their top tier competitors, a claim Marino disputes.

"We have reached out to every one of those hospitals and said, 'If you are interested in working with Horizon on value-based care and payment innovation models, that invitation is there. It's not a monopoly that the only hospital systems that will have access to payment innovation models are the Tier One hospitals,' " he says.

University Hospital was one of the providers that didn't make the Tier One cut, and Kastanis says he wasn't surprised. "I don't see a lot of Horizon Blue Cross patients here, other than those who come through our emergency department. The elective admissions from that third-party payer are minimal," he says.

Still, Kastanis wants UH to be a Tier One provider. "In my first week here I met with Robert [Marino] and we talked about the criteria they used to categorize the hospitals in New Jersey into Tier One and Tier Two. They articulated very clearly the clinical metrics that they wanted to see from those in Tier One because they were going to create incentives for their beneficiaries to go to Tier One hospitals with no deductibles and reduced or no copays," he says.

"The quid pro quo for the Tier One hospitals is they are going to get a discounted reimbursement rate but they are going to get more volume. Guess what: Places that can do that really need scale to absorb and take at-risk the management of these types of patients who are coming to you with a discounted rate."

Kastanis says UH "doesn't quite have that."

"You have to have the confidence and the know-how to do it, and you have to prove to the third-party payer that you really have good clinical outcomes and great patient satisfaction scores; that is going to convince Horizon that they are going to have a good result and good feedback from their beneficiaries," Kastanis says. "Coming here as a newcomer I have to be realistic. We don't have the scale. We can't take a discounted rate just yet. I can pound my chest and say, 'Hey, I'm the only academic medical center in the whole Newark area. We should automatically be included in Tier One!' But, it doesn't hold water."

Marino says UH has clear challenges as an inner-city hospital serving a poorer, sicker patient population, but that some inroads are being made. "The good news is John and I and our staffs have agreed to do some payment innovation models with them," he says. "We are working with University Hospitals here in Newark on a charity program. There is a very significant problem with preterm births at University Hospital, and we are collaborating to improve the health of the mothers and the babies as well. John recognizes that they may not have all the criteria in place, but we are willing to work with any hospital that wants to move in that direction, and clearly John does."

Kastanis sees Tier One status as a long-term goal, one of many affiliations that University Hospital will work toward as the healthcare landscape evolves.

"Specific to OB-GYN they offered that episode of care and I accepted it. I was showing them I am willing to work with them," he says. "It's going to be a gradual improvement in credibility between the two of us to get into Tier One, and I can live with that."

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