Dancing with Elephants!

SC Chapter HFMA
Annual Spring Payor Summit  March 25, 2016
Lynn Bailey, Health Care Economist
Objectives

• A more complete understanding of health care delivery’s restructuring in SC and the nation
• Basic models of consolidation and their variations
• Consolidation ≠ Integration
• Likelihood of success when 70% to 90% of mergers fail
• **Could West Virginia antitrust law ease FTC's scrutiny of local hospital merger?**
  By Lisa Schencker  |  March 21, 2016
  The Federal Trade Commission must soon decide whether to continue challenging a merger between two West Virginia hospitals or drop the fight following the passage of a state law meant to shield such mergers from federal antitrust action.

• **Toshiba selling medical unit to Canon**
  By Adam Rubenfire  |  March 17, 2016
  Toshiba Corp., a manufacturer of imaging equipment, is selling its medical unit to Canon for about $6 billion. The move comes as Toshiba looks to reorganize and refocus its business in an effort to improve its ailing finances.

• **Michigan emergency physicians group to sell for $120 million**
  By Jay Greene, Crain's Detroit Business  |  March 17, 2016
  One of the biggest emergency medical groups in Michigan has signed an agreement to sell its operations to Greenwood Village, Colo.-based Envision Healthcare Holdings for about $120 million, according to Envision.
Private equity firm buys large stake in ExactCare Pharmacy
By Chuck Soder, Crain's Cleveland Business | March 16, 2016
A private equity firm has bought a significant stake in ExactCare Pharmacy—one of the fastest-growing companies in northeast Ohio.

J&J's Ethicon to buy surgical oncology devicemaker
By Adam Rubenfire | March 14, 2016
Johnson & Johnson subsidiary Ethicon announced a deal to acquire NeuWave Medical, a privately held company that makes surgical oncology devices.

Plans move ahead for Allegiance to join Henry Ford Health System
By Associated Press | March 14, 2016
Plans are moving forward for Jackson-based Allegiance Health to join Detroit-based Henry Ford Health System as part of a new affiliation agreement.

Marshfield Clinic will buy instead of build
By Michael Sandler | March 11, 2016
Marshfield (Wis.) Clinic Health System put off its plans to build a new hospital and instead struck a deal to buy a rival hospital.
Terminology

• Horizontal consolidation: acquiring like providers (other hospitals)
• Vertical consolidation: acquiring supply chain providers (physicians, home health, ASCs, imaging centers, urgent care, pharmacies etc.)
• Conglomerate consolidation: acquisition of unrelated business units (media company, interstate trucking etc.)
• Integrated Delivery Network (IDN) : combination of providers and payer(s)
• Cross market: acquisition of unit across geographic service areas
• Same market: acquisitions within a geographic service area
Health Care is just one of many Mega Mergers in 2015

- Beverage: ABInbev & SAB Miller
- Chemicals: Dow & Dupont
- Pharmaceuticals: Pfizer & Allergan
- Health insurers: Aetna and Humana; Anthem and Cigna
- IT and software
Why all these Mega Mergers?

• Rationalize production and reduce costs
• Become more competitive
• Corporations have lots of cash on hand
• US Tax Code
• Consultants lawyers, and investment bankers
• It’s what everyone is doing. It’s popular. Herd mentality.
What an economist expects with increased consolidation

• Microeconomic theory tells me:
  • Reduced output or volume of goods and services. Reduced consumer choice.
  • Increased prices or price above market equilibrium

• Microeconomics also tells me about the critical role of pricing signals
  • Healthcare is NOT a typical market
  • Price doesn’t signal information to supply or demand in healthcare. We get too much or too little.
  • 50% of healthcare is paid by public source with “fixed” prices and 50% is open for negotiation
  • We never answered the question of whether health care is private or public good?
Who are the consolidation policemen?

- States regulate anti-trust activity through attorneys general
- Federal
  - DOJ does criminal
  - FTC does civil
  - CMS does Medicare/Medicaid
- It isn’t illegal to be a big business
- It may be illegal to use certain practices to be big. e.g. price fixing, restraining trade, interlocking governing boards, tying contracts
Extent of health care consolidation

• Alliance models (PHO, MSO, IPA) or the *dismal 1990s* (when health inflation was low)
  
  - garnered few capitated lives from insurers
  - no impact on quality
  - no impact on physician alignment
  - no infrastructure to effectively manage risk
  - bluntly reduced inpatient utilization

• may make a comeback with PPACA

• can serve as the chassis for an ACO
Types of health care consolidation

• Hospitals with other hospitals (horizontal)
• Hospitals with physicians and/or large medical groups (vertical)
• Hospitals with other providers – pre-acute and post acute (vertical)
• Hospitals and health plans (conglomerate or IDN)
• Health plans with providers and other facilities (conglomerate or IDN)
What’s going on in SC?

• Greenville Health System – 8 hospitals, physicians, urgent care, ASCs
• Palmetto Health – Richland, Baptist, Parkridge and Tuomey plus physicians’ practices (private and academic)
• Lexington Medical System – hospital, post acute, ASC and physicians
• McLeod Health System – 5 Pee Dee hospitals, physicians, ASCs
• Roper St Francis – 3 hospitals, ASCs and physicians
• MUSC – broad affiliated network of specialty providers, telehealth
• Alliances across state lines with Novant and Carolinas Medical Center
• Investor owned systems: CHS, Tenet, Lifepoint and HCA
Hospital physician consolidation

• Three types of consolidation or “integration” often identified
  
  • non-economic integration
  • economic integration
  • clinical integration

Source: (Burns & Muller, 2008)
Non-Economic Integration

- Technology acquisition
- Facility upgrade & replacement
- Hospital branding
- Marketing of physician practices
- Physician-to-physician referral programs
- Increased number and skill-mix of nursing staff
- Convenience of scheduling tests and procedures
- Medical staff development plans
- Medical office buildings

- Clinical councils
- Physician liaisons and mediators
- Physician sales and outreach programs
- Physician surveys and focus groups
- Physician retreats
- Physician leadership development
- Hospital committees
- New technology and value analysis committees
# Economic Integration

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- **PHO/IPA Risk Contracts with Payers**
- **Supply Chain Management Programs**
- **DRG – Specific Bundled Payments**
- **Hospital Provision of In-kind Services for Cost Savings**
- **Equipment Leases**
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- **Retail Clinics**
- **Product Line Centers**
Clinical Integration

- Guidelines, pathways, protocols
  a) development
  b) implementation
- Physician & episode profiling
- Physician performance feedback
- Physician credentialing
- Common patient identifier
- Disease registry
- Case management
- Medical management committee
- Disease management
- Demand management
- Clinical information systems
- Patient self-management skills and education

- Clinically integrated networks (CINs)
- Quality improvement steering councils
- Continuous quality improvement
  a) inpatient
  b) outpatient
- Clinical service lines
  a) inpatient
  b) outpatient
Drivers of consolidation

**Hospital Goals**
- Increase MD incomes
- Improve care processes & quality
- Share cost of clinical IT with physicians
- Prepare for ACOs and Triple Aim
- Increase leverage over payers
- Increase physician loyalty/alignment
- Minimize volume splitting
- Increase hospital revenues
- Capture outpatient market
- Mitigate competition with physicians
- Develop regional service lines
- Create entry barriers for key clinical services
- Recruit physicians in specialties with shortages
- Address medical staff pathologies

**Physician Goals**
- Increase MD incomes
- Increase quality of service to patients
- Increase access to capital & technology
- Uncertainty over health reform
- Low leverage over payers
- Escape administrative hassles of private practice
- Escape pressures of managed care
- Exit strategy for group’s founding physicians
- Increase predictability of case load & income
- Increase physician control
- Increase career satisfaction & lifestyle
Another perspective on types of consolidation

- Three types of relationship often identified

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History of Payer-Provider Integration

- 1930s & 1940s: Group/staff model HMOs (e.g., Kaiser, GHC, etc.)

- 1970s - 1980s: IPA model HMOs (e.g., Hill Physicians)

- 1970s – 1980s: Rural-based IDNs develop health plans (Geisinger, Carle, Scott & White, etc.)

- 1980s: insurers acquire primary care groups, investor-owned hospitals acquire insurers

- 1990s: insurers sell off primary care groups to PPMs

- 1990s: nonprofit hospitals get into insurer business in anticipation of capitated care partly stimulated by BBA ‘97 (Provider-Sponsored Organizations)
Hospital Sponsored Health Plans

• First wave interest peaked in mid-1990s
• Products rarely achieved substantial scale (failure to reach MES ~ 100K lives)
• Host of problems (Burns & Thorpe, 2000):
  
  Under-capitalization
  Inability to sufficiently grow & compete
  Substantial financial losses in early years
  Huge medical loss ratios
  No actuarial or marketing expertise
  Conflicting capital needs with rest of system
  Internal conflicts: cost minimization v. revenue maximization

• Viable in selected markets where a large plan dominates market (e.g. Lansing, Indianapolis)
• Exclusive affiliations with plans obviate value of plan sponsorship
• Provider plans die off in late 1990s and early-mid 2000s as market transitions to open-access
Provider-led Integration with Payers: Why?

• Position themselves to manage risk-based contracts

• Position themselves to become ACOs

• Position themselves for population health management

• Gain some leverage over payers

• Never-ending effort to dis-intermediate payers

• Never-ending effort to manage care continuum and triple aim
Is BIG BETTER?

• Economies of scale: reducing average costs. Dealing with high overhead. Insurers looking to lower cost per member. Invest in new services.

• Negotiating leverage with provider and payors: Healthcare is basically still local. Cross market vs same market.

• Diversification or “Synergy” (whole greater than sum of parts): The tooth fairy of all M&As.
The role of ACA and ACOs

• ACA is the spark of the latest round of consolidation. 100+ in 2014 and 130+ in 2015. It’s a herd mentality
• Vertical and horizontal
• ACA links reimbursement to improved quality and lower total cost and accepting risk based payments for populations
• Pushing the concept of “population health.”
• Mergers spread risk over larger population.
• Mergers also reduce competition and raise prices
Searching for the next Kaiser Permanente

• Kaiser is the “new holy grail.”
  • Kaiser was begun with MDs, and insurance then added hospitals
  • Physician based clinical model not hospital centered
  • Kaiser has had mixed results moving its model out of California

• The cultural barrier of physician centered/lead vs. hospital centered. This is the Grand Canyon of cultural divides

• Can’t integrate clinical care (quality) with out coordination of physicians and hospital. Currently two armed camps in détente.

• IT has allowed for better tracking of physician productivity and better compensation model for physician but not better clinical quality.
Recent Payer-Provider Deals in Vertical Integration

Insurers Buying Physician Groups

- WellPoint acquires CareMore (26 clinics in California)

- Humana acquires:
  - Concentra - occupational medicine chain Concentra (2010)
  - SeniorBridge - home health provider and 1,500 care managers (2011)
  - NextCare - urgent care center chain (2011)

- UnitedHealth/Optum acquires:
  - Monarch medical group (2011)
  - network of 425 “affiliated” (e.g. employed)
  - network of 4,500 “contracted” physicians,
  - 300 nurse practitioners and physician assistants in 90 primary care and urgent care clinics
Hospital Sponsored Health Plans: Research Evidence

- IDN investment in hospitals/MDs/health plans negatively associated with operating margin
- Hospital diversification into other business lines like health plans associated with higher debt-to-capitalization ratios
- Health plan investments to link with providers to serve the Medicare Advantage population linked to higher premiums
- CMS announced in December 2015 that only 58 of 330 ACOs [that’s 18%! ] participating in the “Shared Savings Program” actually managed to hold spending below their benchmarks but there is little evidence of improved quality.
- The current ACO model is hospital based and not physician managed.
- The evidence to date, slim but patients lose choice and face higher costs/premiiums.
- Harming competition we’re not be able to undo. Unscrambling the eggs!

Payer-led Integration with Providers: Rationale

• Position for increased Medicare Advantage enrollment, which has been surging and will increase substantially with the retirement of the baby boomers, as well as for increased Medicaid enrollment following PPACA implementation in 2014.

• Develop networks to help manage the care of the sickest patients - such as the chronically ill, the dual eligibles, and those with pre-existing conditions - which are the target of several initiatives in the ACA.

• Belief that the only way to manage risk contracts and satisfy the dictates of value-based contracting is by owning the front end of (ambulatory) care and incentivizing their employed physicians to treat enrollees cost-effectively

• Threat posed by hospital efforts to develop captive physician networks and ACOs which might have as their real goal limiting insurer contracting options and increasing the prices charged them. Insurers may be vertically integrating back into the physician market to develop countervailing power and/or avoid being locked out
Innovations—clinical or organizational?

• Chief Information Officers have they made a difference?
• Innovation centers? Are they truly innovating or transforming care or rearranging the deck chairs on the Titanic?
• How involved are hospital employees?
• Is it possible to regain the scale required to reasonably spread risk?
Closing thoughts

• Healthcare providers are risking significant lose of trust with their stakeholders.

• The odds aren’t in BIG HEALTHCARE’s favor....across the US and world economy 70% to 90% of ALL M&As FAIL! Is healthcare that different?

• Anti-trust actions
  • State level: Massachusetts
  • FTC: Mostly focused on hospital and hospital mergers and market concentration. It’s what they know how to litigate

• Return to a basic question? Is health care a public or private good? How will we allocate resources if remain semi-public/private.
When the elephants dance
the grass gets trampled.