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## Healthcare Business News

### Consolidation creating giant hospital systems

By [Melanie Evans](#)

Posted: June 21, 2014 - 12:01 am ET

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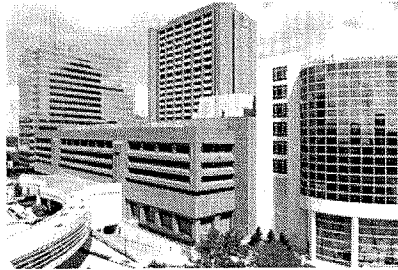
Large regional and national healthcare systems are getting bigger and markets are increasingly consolidating, Modern Healthcare's annual survey of hospital systems shows.

Among the nation's biggest for-profit and not-for-profit systems, dealmaking in 2013 created giants with multibillion-dollar annual revenues that rival some Fortune 500 companies. Regional systems acquired nearby hospitals to strengthen their position as local players. And nearly all systems added more physicians to their payrolls: Among survey respondents, doctors employed by systems increased 39% to roughly 67,600 physicians.

The largest U.S. health system by revenue is [HCA](#). The Nashville-based for-profit system ended 2013 with net patient revenue of \$38 billion and the No. 1 spot in Modern Healthcare's ranking.

[Ascension Health](#), the second-largest system by revenue, acquired regional health systems in Kansas, Oklahoma and Wisconsin, adding nearly \$4 billion in revenue and 32 hospitals to the St. Louis-based system's portfolio. Not-for-profit Ascension ended 2013 with patient revenue of \$15.3 billion.

For-profit [Community Health Systems](#), which ended 2013 with 133 hospitals and revenue of close to \$13 billion, ranked No. 3. [Trinity Health](#), Novi, Mich., and Catholic Health East, Newtown Square, Pa., merged to create not-for-profit behemoth CHE Trinity Health with more than \$12 billion in operating revenue, making it the fourth-largest system.



St. Luke's Hospital, the flagship of Houston's St. Luke's Episcopal Health System, was acquired by Catholic Health Initiatives

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The consolidation activity—likely to continue this year with a flurry of recently proposed

#### MH Takeaways

The trend for health systems to acquire physician practices has the potential to raise prices, particularly under the current volume-based fee-for-service system.

unions—underscores the jockeying among health systems as public policy and market forces expand insurance coverage for millions of Americans, push providers to manage the health of enrolled populations and shift payment to new models that introduce greater financial risks for hospitals and doctors.

Systems are striking deals that deliver larger scale, more leverage and more diverse business lines that executives contend are needed to manage increased insurance risk and reduce wasteful fragmentation. Dealmakers say they hope to improve quality and reduce costs through greater standardization of care, more negotiating leverage with suppliers, and bigger investments to bolster providers' ability to communicate and coordinate care.

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But consolidation also carries the risk of reducing competition and raising prices. "The problem is, coordination and competition are kind of antithetical," said Mark Pauly, a professor of healthcare management at the University of Pennsylvania.

The wave of dealmaking has attracted regulators' scrutiny. In January, a federal judge agreed with the Federal Trade Commission's argument that Boise-based St. Luke's Health System gained too much market clout when it acquired a large local medical group; he ordered the system to unwind the deal. "Our job is to protect American consumers," said

Martin Gaynor, director of the FTC's bureau of economics. **Mergers** in highly concentrated healthcare markets can raise prices, which hits consumers with higher premiums, higher cost-sharing and slower wage growth, he said.

## Market-share gains

Experts say the trend among health systems to acquire physician practices also has the potential to raise prices. Health systems that employed doctors and made market-share gains raised prices 2% to 3%, according to an analysis of market-share shifts and price changes between 2001 and 2007. The study was published in May in Health Affairs. Laurence Baker, a professor of health research and policy at Stanford University and author of the study, said the results suggest savings from employing physicians won't be "easy or automatic."

Insurers lose bargaining power when hospitals and doctors jointly negotiate prices, said Dr. Ann O'Malley, a senior fellow with Mathematica Policy Research. The risk of increased costs because of consolidation is greatest under fee-for-service reimbursement tied to volume of services. "Hospitals ... would like to garner more referrals to their specialists" by employing more doctors, she said. "In the short term, there's a real risk that costs could really go up."

Modern Healthcare's rankings capture a sizable number of major health systems. But because the survey is voluntary, it does not fully reflect the U.S. hospital market. For some non-respondents, Modern Healthcare used publicly available financial data, such as for Tenet Healthcare Corp., which last year acquired Vanguard Health System. Tenet reported operating revenue of \$11.1 billion in its regulatory filings, including Vanguard revenue for the final three months of 2013. Vanguard reported annual revenue of \$6 billion before the deal. Tenet did not respond to the survey.

For systems that did not respond, details on physician employment and ambulatory growth were not available. Among the non-respondents that ranked among the nation's larger systems were Allina Health, Minneapolis; BJC HealthCare, St. Louis; Bon Secours Health System, Marriottsville, Md.; Partners HealthCare System, Boston; Texas Health Resources, Arlington, Texas; and UPMC, Pittsburgh.

The survey did not capture deals closed after the end of systems' fiscal 2013. Baylor Health Care System merged last October with Scott & White Healthcare after the close of Baylor's fiscal year. The newly created \$8.3 billion Texas system is not included in this year's ranking. Also not included is the \$3.9 billion deal by Community Health Systems, Franklin, Tenn., for Health Management Associates, Naples, Fla. The deal closed in January.

Dealmakers cite early success in cutting costs as evidence that bigger is better. Leaders of CHE Trinity Health said the combined system's larger size has yielded savings and new business opportunities. Greater efficiencies because of scale have shaved operating expenses by \$128 million in the first year of the merger, while combined quality, clinical and information technology staff have allowed more rapid adoption of strategies to reduce waste and harm. "We just multiplied the ability to get good ideas and to replicate those good ideas across the system," said Daniel Hale, executive vice president of the system's Institute of Health and Community Benefit.

Hale downplayed the risk that consolidation will reduce competition and raise prices. "Size creates a lot of possible, really positive opportunities for us," he said. Operating in 20 states allows CHE Trinity to better compete for contracts from national insurers serving multistate employers, he said.

Catholic Health Initiatives, which ranked No. 7 on this year's list, grew larger as the system entered a new state. Last year's deal made by the Englewood, Colo.-based system for St. Luke's Episcopal Health System, Houston, added \$1.2 billion in revenue to CHI's operations, to increase its revenue to nearly \$9.9 billion.

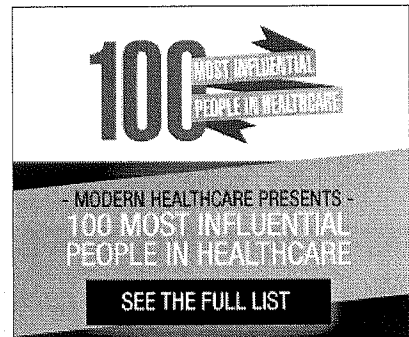
Mergers between giant health systems are not the only deals taking place. Smaller health systems have merged to create formidable regional players, and more deals are on the way to reshape local markets. In May, University of Wisconsin Health System announced plans to merge with SwedishAmerican Health System in Rockford, Ill. In March, St. Anthony's Health System, Alton, Ill., announced a potential merger with OSF HealthCare System, Peoria. Beaumont Health System in Royal Oak, Mich., announced a possible merger with Botsford Health Care in Farmington Hills and Oakwood Healthcare in Dearborn to create a \$3.8 billion system.

## Strategy to diversify

In addition, health systems continued to acquire physician groups as part of their strategy to diversify into ambulatory care. That trend also was reflected in the growth of freestanding outpatient-care centers owned by health systems, which increased 27% to 6,045 centers.

SSM Health Care, St. Louis, gained 500 physicians and 60 clinics last year with its acquisition of Wisconsin-based Dean Health System. That increased the 15-hospital system's roster of employed physicians by 46% to 1,300 doctors.

"From our perspective, we were purposely trying to move beyond a hospital system to truly being a system that's trying to keep people healthier, and hospitals are not the best place to do that," said William Thompson, SSM's president and CEO.



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"To truly improve the experience and lower the total cost, we needed physicians to take the lead in the delivery of care and assume positions of leadership in all levels of the organization."

SSM will seek to employ more doctors across its markets to prepare for contracts to manage the health and healthcare costs for enrolled patient populations, Thompson said. SSM's deal for Dean Health System gives it access to a profitable medical group's management expertise, which SSM leaders will tap as they expand physician hiring. "We recognized that hospital systems do not manage physician groups well," Thompson said.

Ascension Health, St. Louis, reported a 93% increase in physician employment in 2013 to 5,252 doctors. But the tally for 2013 included hospital-based and academic doctors not counted in the 2012 total. The system's acquisition of three regional health systems boosted its total of employed doctors by 1,000 physicians.

Dr. David Pryor, president and CEO of Ascension Clinical Holdings, said his system tailors its physician employment strategy to each market, and will continue to work with independent doctors as it pursues a strategy of building regional networks. "There are very strong physician groups in many markets who are key to delivering high-quality care, but they may choose to stay independent," he said.

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## Accountable Care Organizations — The Risk of Failure and the Risks of Success

Lawrence P. Casalino, M.D., Ph.D.

An accountable care organization (ACO) consists of health care providers who collectively agree to be held accountable for the care they provide to the population of patients attributed to their ACO. Two and a half years after the beginning of the Medicare ACO programs mandated by the Affordable Care Act, there are 361 ACOs contracting with Medicare<sup>1</sup> and hundreds of ACO-like contracts in the private sector. Payers — Medicare and health insurance plans — give ACOs financial incentives to invest in processes to systematically and proactively improve quality and control the costs of care for their populations of patients.

In this issue of the *Journal*, McWilliams et al.<sup>2</sup> provide the first evidence from a large-scale study of patients' experiences in ACOs. Using a difference-in-differences analysis, they found that patients' experiences during the first year of the Medicare ACO program improved more for Medicare beneficiaries attributed to ACOs than for beneficiaries not attributed to ACOs in two important measures: timely access to care and primary care physicians being informed about specialist care provided to their patients. Patients in ACOs did not differ significantly from control patients in their overall rating of care. However, in a prespecified subgroup analysis that included only patients with multiple chronic conditions, patients in ACOs reported better overall experience of care than patients in the control group. These are the patients to whom ACOs direct most of their care improvement processes.

Also in this issue, Song et al.<sup>3</sup> report results from the first 4 years of the Blue Cross Blue Shield of Massachusetts (BCBS) Alternative Quality Contract, which now includes approximately 85% of all physicians in the BCBS network and is the best known of the private-sector ACO contracts. Using a difference-in-differences analysis, Song et al. found significant savings ranging from 5.8% to 9.1% across the years and cohorts of ACOs in the program. Incentive payments to the ACOs exceeded savings to the health plan during the first 3 years, but by the fourth year savings exceeded incentive payments.

The ACOs also performed better on multiple quality measures as compared with national and New England averages. Finding an appropriate comparison group of providers was problematic, and the results could be confounded by other quality-improvement and cost-control efforts in Massachusetts during the past 4 years. However, Song et al. conducted multiple sensitivity analyses that support their findings.

The results of these two studies are broadly consistent with recent reports from the Centers for Medicare and Medicaid Services (CMS) that ACOs in the CMS programs have on average achieved modest reductions in costs for Medicare beneficiaries, thereby generating "shared savings" revenue for themselves and net savings for CMS, and have improved their performance on nearly all quality and patient-experience measures included in the program.<sup>4,5</sup> The results of these two studies are also consistent with a recent evaluation of the Medicare Physician Group Practice Demonstration (the predecessor to the ACO program) that showed improvements in quality scores and modest reductions in cost.<sup>6</sup>

The fledgling ACO movement involves two large risks. The first is that it will fail. The second is that it will succeed, but for the wrong reasons.

Traditionally, physicians and hospitals have been paid on the basis of the volume of services they provide to whichever patients happen to seek care, without regard to the appropriateness or quality of these services. They are not paid to identify patients who are in most need of care and to give them whatever attention they need, to use nurses and other staff to help patients learn how to manage their chronic illnesses, or to communicate with patients by phone and e-mail as well as in face-to-face visits. ACOs represent the best attempt to date to move away from business as usual and toward health care that will improve patients' health and will not bankrupt the country. If ACOs fail, it may be a long time before a similarly bold concept emerges.<sup>7</sup>

Despite rapid growth, the success of the ACO

movement is far from certain. The performance of ACOs to date has been promising but not overwhelming. Although some ACOs have gained a substantial return on their investment in improving the health of their patients, many have not.<sup>1,4,8</sup> Furthermore, unless and until a high percentage of their patients — including privately insured patients — are covered by ACO contracts, hospitals and physicians will be in the difficult position of dealing with diametrically opposed sets of payment incentives.<sup>9</sup> One set rewards increasing the volume of services provided, and an opposing set rewards containing costs and improving quality. In addition, CMS ACO programs as currently constituted are frequently criticized for lack of flexibility, inaccuracies in attributing patients to ACOs, and incentive formulas that penalize ACOs that are already providing cost-effective care.<sup>1</sup> Some prominent hospitals and medical groups have decided not to sign a CMS ACO contract or have dropped out — for example, more than one third of the vanguard ACOs in the Pioneer program have withdrawn from it.<sup>4</sup> The ACO movement is unlikely to succeed unless health insurance plans dramatically increase their number of ACO contracts and unless CMS modifies specifications for its ACO programs — a course that the agency is considering.<sup>1</sup> Even then, many if not most ACOs may take years to reach their potential for improving care, and it is possible that neither policymakers nor ACO leaders will be willing to wait that long.

It is also possible that the ACO movement will succeed, but for the wrong reasons. The movement has added impetus to efforts by hospitals to merge with each other and to purchase physician practices. Hospitals can bring substantial resources to ACOs. However, very large, hospital-centered ACOs could dominate the market not by providing better care at reasonable cost but possibly by commanding high payment rates from health insurers, marginalizing smaller

hospitals and medical groups, and consigning the experience of human scale in medical care to oblivion. Antitrust enforcement may not be enough to avoid this outcome.<sup>10</sup> It would be helpful if more physicians step up to the plate and take an active role in organizing and governing ACOs — a role that CMS and health insurers encourage.<sup>7,11</sup>

Disclosure forms provided by the author are available with the full text of this article at [NEJM.org](http://NEJM.org).

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