

Academic Medical Centers Joining forces with community providers for broad benefits and positive outcomes

Executive summary

Academic Medical Centers (AMCs) are among the US hospitals with the strongest name recognition and reputation.¹ Yet even they have not been immune to the forces transforming the larger health care marketplace. Like the majority of US health systems, AMCs are consolidating and broadening their relationships with other hospitals, physicians, and other care providers in the community. These relationships can take many forms — mergers and acquisitions (M&A), affiliations, collaborations, partnerships, joint ventures (JVs), or other deal structures. Such AMC-led consolidation can have broad benefits and positive outcomes for the AMC, community providers, and consumers.

AMC-driven M&A has been common the past few years,² as have affiliations, collaborations, partnerships, and JVs. Note that consolidation can be vertical (AMCs acquiring post-acute providers) or horizontal (AMCs acquiring acute care hospitals and physicians); this paper focuses on horizontal consolidation. Deloitte's analysis of M&A datasets, interviews with AMC executives, and case studies highlight several AMCs and their strategies for navigating the changing health care marketplace via consolidation. The results show that building relationships with community health systems and physicians is part of AMCs' strategy to remain relevant and be successful in the future. AMCs' goals and outcomes for consolidation include:

- Performance improvement (financial, operational, and clinical), including cost reduction
- Revenue diversification

- Inclusion in payer networks and protection and expansion of referral sources

After analyzing M&A data from 2007-2013, Deloitte found that AMC-led consolidation produced considerable benefits. For AMCs that purchased at least one other hospital during 2009 and 2010, their core location:

- **Performed better overall financially.** The AMC's earnings before interest, taxes, depreciation, and amortization (EBITDA) improved post-acquisition. The improved EBITDA performance likely is a result of increased case mix index (CMI).¹
- **Reduced expenses.** After an initial rise in expenses, likely due to post-merger costs, operating expense per patient day two years post-acquisition were reduced.
- **Increased CMI.** Post-acquisition, AMCs treated more higher-acuity patients, who typically have higher payments from payers due to treatment complexity. This likely is a result of shifting patients to the right care setting (community vs. AMC) based on case complexity.

Like any organization, AMCs may experience cultural, financial, and bureaucratic challenges to consolidation. However, AMCs that are currently developing their M&A strategies can learn from their counterparts highlighted in this paper.

¹ Case mix index (CMI) is a relative value assigned to a diagnosis-related group of patients in a hospital and represents their acuity and complexity. Adjusting for CMI mitigates differences across hospitals for patient risk, acuity, and complexity and allows comparison. A higher CMI means more complex and higher acuity patients.



New landscape, new pressures for AMCs

Traditionally, AMCs have been standalone organizations (rather than part of a health system) and, to a certain extent, “ivory towers” shielded from the pressures and constraints of typical community health systems. AMCs’ position may be attributable, in large measure, to US health care’s long-time, volume-based, fee-for-service (FFS) payment system. Under FFS, many AMCs have been rewarded financially because, as destinations for complex patients and training grounds for medical care, they typically have treated higher volumes of patients compared to other hospitals and have commanded a premium in reimbursement. However, the marketplace is changing and AMCs are no longer immune from reimbursement pressures. Since many AMCs have higher unit costs,³ some are being excluded from health plan networks and are having their referral patterns disrupted.

AMCs are facing the same market, financial, and regulatory challenges as other US health systems, but may be finding it more difficult to navigate the changing environment due to their inherent structural and operational differences, which include:

- An AMC’s tripartite mission and business model combine research, education/medical training, and clinical patient care.
- A larger share of AMC patients are typically uninsured or have Medicare or Medicaid coverage.⁴
- AMC costs are typically higher than those of community health systems.⁵
- An AMC’s focus is on specialty care to an even greater extent than other health systems.⁶

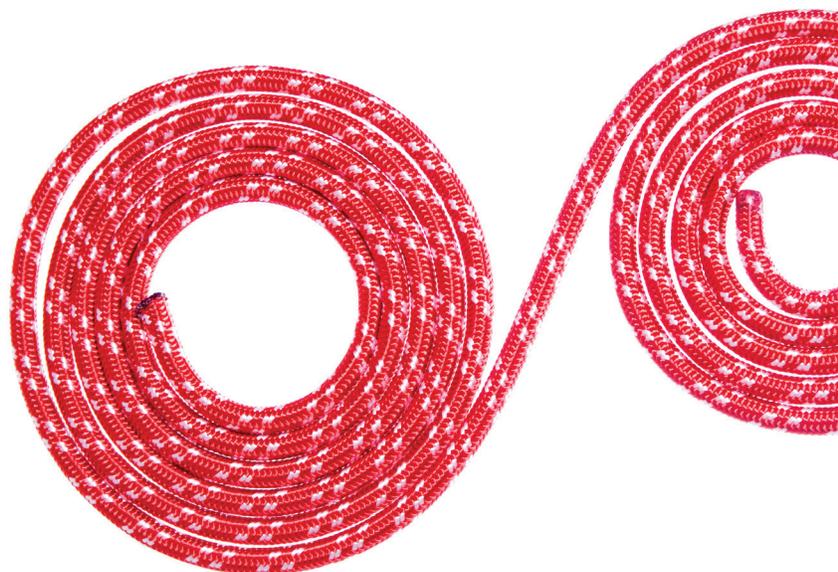
Adding pressure, newer challenges for AMCs are emerging:

- Value-based care (VBC) payment arrangements call for more integrated networks.
- Health plans are developing narrow networks that exclude higher-cost providers without discernable clinical benefit as a way to lower costs.
- Despite name recognition and positive reputations among consumers in many markets,⁷ AMC quality outcomes are mixed.⁸
- Education and research funding is flat or declining.⁹
- More health systems and other organizations are competing for complex patient treatment and research opportunities.
- Retail and urgent care growth is disrupting referral patterns.
- Growing consumerism is requiring health systems to offer broader, more accessible physician networks.

VBC and narrow networks are two of the greatest potential disruptors for AMCs, as both directly challenge their traditional market positions.¹⁰ Both efforts seek cost savings, to the potential detriment of an AMC. VBC payment models favor organizations that provide lower cost of care and have a strong primary care focus;¹¹ AMCs traditionally focus on specialty care. AMCs’ higher cost position also makes their inclusion in narrow networks challenging.

VBC strategies are intended to lower costs, improve quality and outcomes, and align incentives. They press health systems and physicians to take on financial risk, share in savings, or receive payments based upon the quality of patient care.¹² Doing so is likely to require a more holistic approach to patient care versus treating an episode or single illness. Health care providers, therefore, may need to add capabilities such as enhanced preventive services, coordinated follow-up care, and multiple settings of care — capabilities that some AMCs (and many community health systems) currently lack.

Over the last few years, some AMCs have pursued traditional hospital M&A (full mergers or asset exchange) as a tactic to position their organization more favorably in the market and address some VBC-related challenges. However, traditional hospital M&A has plateaued among AMCs in the past two years.¹³ This may be due to financial constraints (lack of access to capital due to credit rating downgrades at some AMCs¹⁴ and university control of AMC budgets) and regulatory scrutiny.¹⁵ AMCs, like other health systems, are now pursuing broader relationships.



AMCs respond to the shifting landscape

How have AMCs responded thus far to the shifting health care landscape? Deloitte’s analysis of M&A and financial datasets, interviews with AMC executives, and market case studies highlight three strategies and capabilities (detailed below) that AMCs seek through consolidation:

1. Performance improvement (financial, operational, and clinical: Cost reduction, M&A synergies, strategic cost positioning, readmissions)
2. Revenue diversification (new revenue streams, referral sources for complex patients)
3. Inclusion in payer networks and protection and expansion of referral sources (expanded physician networks, retail offerings, partnerships with health plans).

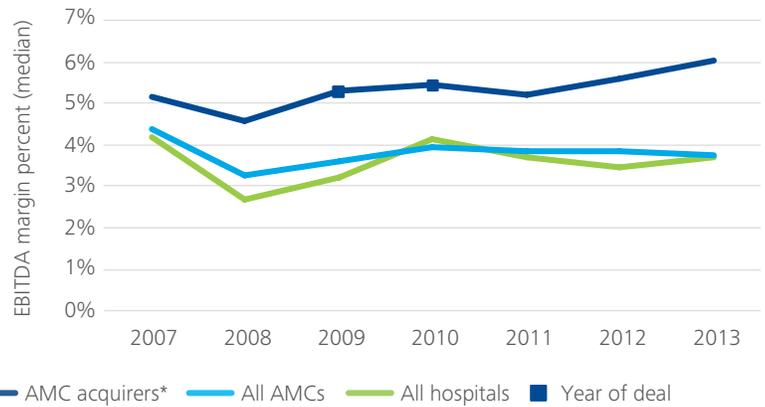
Implementing these interrelated strategies and capabilities may help AMCs navigate VBC and narrow networks. They also may produce broader benefits and positive outcomes for AMCs, community providers, and consumers, as evidenced by Deloitte’s analysis of past AMC-driven consolidation.

1. Performance improvement

Analysis of M&A data from 2007-2013 reveals that AMCs which acquired at least one community hospital improved performance at their core AMC location on several measures — higher profit, lower expenses, and higher case mix. Based upon hospital acquisitions in 2009 and 2010, financial indicators show that the AMCs which acquired a community hospital were large and had strong performance; these institutions grew even larger and had healthier performance post-acquisition. The deals also resulted in broader benefits — to the AMCs, community providers, and consumers. The benefits included the shifting of patients to the appropriate setting of care, which reduces costs and can improve population health.

AMCs which acquired a community hospital in 2009 and 2010 also improved overall financial performance, based upon median earnings before interest, taxes, depreciation, and amortization (EBITDA) (Figure 1). From 2011-2013, median profitability for all hospitals and all AMCs remained relatively flat with slight shifts. However, AMCs which acquired a community hospital in 2009 and 2010 saw the median profitability of their core AMC location grow by 16.1 percent from 2011-2013. It is assumed that these AMCs successfully implemented cost management and patient-shifting strategies, as explained in Figure 1.

Figure 1. AMCs that acquired hospitals improved EBITDA post-acquisition¹⁶

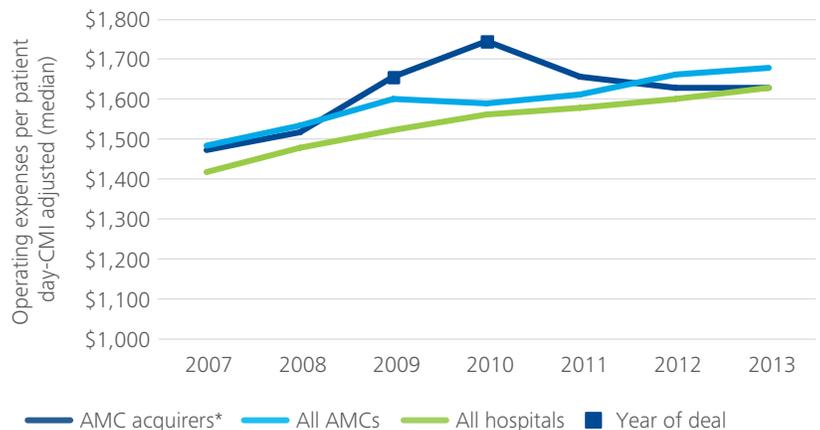


Source: Deloitte analysis of hospital acquisition deals from Modern Healthcare M&A Trends Database (2007-2014) and financial metrics from Truven Health Medicare Cost Report data (2007-2013).

* Based upon AMCs acquiring at least one community hospital in 2009 and 2010 (17 deals) and core AMC location.

While operating expenses initially increased for AMCs which acquired at least one community hospital in 2009 and 2010, expenses at their core AMC location subsequently fell (Figure 2). These AMCs decreased their operating expenses per patient day (CMI adjusted) by 6.8 percent from 2010-2013. By 2013, these AMCs had lower operating expenses than other AMCs and expenses similar to those of non-AMC hospitals.

Figure 2. AMCs that acquired hospitals reduced operating expenses post-acquisition¹⁷



Source: Deloitte analysis of hospital acquisition deals from Modern Healthcare M&A Trends Database (2007-2014) and financial metrics from Truven Health Medicare Cost Report data (2007-2013).

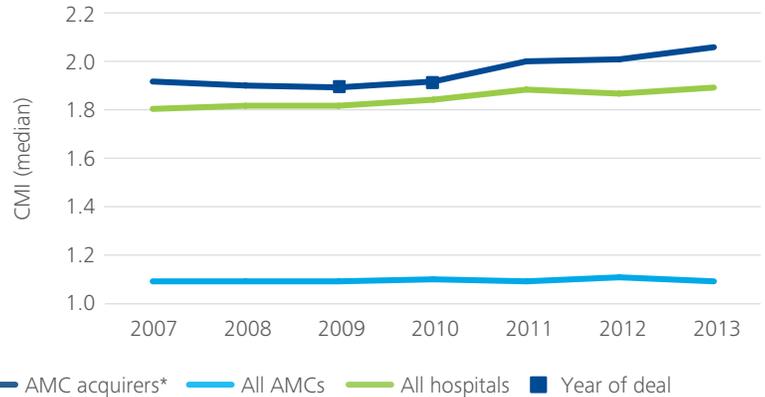
* Based upon AMCs acquiring at least one community hospital in 2009 and 2010 (17 deals) and core AMC location.

In addition, AMCs that acquired at least one community hospital in 2009 and 2010 increased CMI at their core AMC location post-deal (Figure 3). AMCs typically treat a more complex patient population than other hospitals; however, AMCs that acquired a community hospital treated patients who were more complex and had higher acuity than other AMCs. From 2010-2013, the CMI of acquiring AMCs increased by 7.5 percent compared with all AMCs, which saw a CMI increase of only 2.7 percent.

Based on the EBITDA, operating expenses, and CMI results, it appears that AMCs that acquired at least one community hospital in 2009 and 2010 had success with shifting patients to the appropriate care setting (referred to as strategic re-positioning of services). Lower-cost patients (lower complexity and CMI) were likely shifted away from the AMC to the acquired community hospital. Higher-cost patients (higher complexity and CMI and, subsequently, higher payments) were admitted to the AMC. Patient shifting benefits both the AMC and community providers because they keep care local and treat patients in appropriate settings. It also can benefit consumers and broader population health through cost savings and provider coordination and expertise.

Beyond traditional M&A, AMCs improved their performance through other relationships with community health systems and physicians. Montefiore Medical Center, for example, established a Pioneer Accountable Care Organization (ACO) as part of a Medicare pilot program in partnership with two community health systems and two community physician groups.¹⁹ Together, they leveraged analytics to identify high-cost patients and patients at risk of readmissions.²⁰ The community providers and the AMC then partnered to care for those patients by integrating PCPs and specialty care services, assigning patient educators and care managers, ensuring follow-up care, and offering comprehensive outpatient services.²¹ The result was a “substantial reduction”²² in readmissions relative to other ACOs. Due to these efforts, the Montefiore ACO had the best financial performance among the 32 Pioneer ACOs in 2013, the program’s first year.²³ By 2014, Montefiore ACO had \$27.4 million in savings in its first two years.²⁴

Figure 3. AMCs that acquired hospitals increased CMI post-acquisition¹⁸



Source: Deloitte analysis of hospital acquisition deals from Modern Healthcare M&A Trends Database (2007-2014) and financial metrics from Truven Health Medicare Cost Report data (2007-2013).

* Based upon AMCs acquiring at least one community hospital in 2009 and 2010 (17 deals) and core AMC location.



2. Revenue diversification

Several AMCs diversified their revenues by entering into various types of community health system and physician relationships. Interviewed AMC executives explained that, through these affiliations and partnerships, they could expand in the market more quickly and without acquisition-related risks or capital requirements. The relationships also generated new revenue streams, according to the interviewees.

Licensing an AMC's brand and intellectual property (IP) for quality improvement is one channel for revenue diversification, the interviewees noted. AMCs demonstrating high quality can leverage their brand to sell its standards and protocols for improved quality practices at community providers. Not only is this an opportunity to create new revenue-generating business lines, it is a way to gain access to new referral sources for complex patients. For example, Mayo Clinic in 2011 launched an affiliate business through its clinical, education, and research arm, Mayo Clinic Care Network (MCCN), which extends knowledge and expertise through formal collaboration and information-sharing tools with subscribing community health systems and physicians throughout the US, Mexico, Puerto Rico, and Singapore.²⁵ To date, the network has more than 30 members with more than 85 hospitals.²⁶ The benefit for members is physician access to Mayo's knowledge and expertise.²⁷ Mayo's goal through the network is to leverage knowledge, so physicians can collaborate to improve the delivery of health care in the local community setting and help more patients avoid unnecessary travel. The benefits for Mayo Clinic include gaining closer relationships with like-minded organizations, extending Mayo's relevance and its reach, generating revenue through member subscription fees, and gaining referrals for complex patients.²⁸ Of the nearly 2,000 consults submitted to MCCN by affiliate members in 2014, less than 15 percent were referred to Mayo Clinic for additional assessment or clinical care.²⁹

To enter new markets more quickly than with a traditional acquisition, North Shore-Long Island Jewish (NSLIJ) Health System also is advancing an affiliated network program in which it shares quality protocols developed by its AMC location, and supports quality and administrative initiatives, with community health systems and physicians throughout the country.³⁰ The affiliations enable NSLIJ to collaborate with community providers for best practices in patient care, clinical quality, and expense reduction.³¹ The program's goals are to improve quality, add value for community providers, and expand geographic relationships. While the initiative is still in early stages, it intends to benefit NSLIJ via revenue generated from the affiliation fees and potential future collaboration opportunities.³²

Duke University Health System formed a joint venture with for-profit hospital chain LifePoint Hospitals to acquire community health systems and focus on quality improvement. Duke LifePoint Healthcare is a unique relationship between an AMC and a for-profit hospital operator in which Duke provides quality guidance and standards, and LifePoint provides capital, financial, and operational support.³³ The acquired community health systems benefit from both organizations. Since its inception in 2011, Duke LifePoint Healthcare has acquired 12 community health systems throughout the country.³⁴ Financially, the JV has had significant growth: Revenue increased from \$282 million in 2012 to \$512 million in 2013, and is expected to grow to \$1.5 billion by 2015.³⁵ The relationship also enables Duke University Health System to reduce the typical barriers (capital constraints) and risks of doing an acquisition on its own. In addition, the relationship gives Duke the ability to invest in continuous quality improvement and development programs throughout the system.

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3. Inclusion in payer networks and protection and expansion of referral sources

Many AMCs in the research literature and interviews provide examples of strategies to mitigate the challenges of health plan narrow networks. Some have expanded their physician networks while others have partnered with payers, operate in global markets, or have entered the retail clinic market. AMCs focused on expanding their physician networks acquired, partnered, and collaborated with community health systems and independent physicians to grow their geographic presence and add PCPs — both to address the growing challenges of VBC payment models, narrow networks, and consumerism. These efforts and relationships also help community partners by bringing certain specialty services to their patients.

Stanford Health Care both acquired and partnered to broaden its geographic presence and service offerings. Stanford Health Care formed the University Healthcare Alliance (UHA), an affiliated medical foundation which aligns community physicians within Stanford Health Care's broader regional network of care. A number of initial medical groups joined the foundation network, and subsequent physicians were recruited into Stanford UHA.³⁶ Stanford Health Care then acquired an existing Independent Practitioner Association (IPA), further expanding its network capabilities. By growing faculty physicians and by regionally expanding primary and specialty care with UHA, Stanford Health Care nearly doubled the number in its physician network.³⁷ Stanford Health Care also acquired ValleyCare Health System, including its two hospital campuses and its ambulatory locations, expanding beyond Stanford's historic direct primary service area.³⁸ Finally, Stanford Health Care developed multiple regional outpatient centers for cancer, imaging and surgery, across its broader network. Through all of these efforts community providers have been able to join in Stanford Health Care's efforts to deliver specialty care in the region, improving regional access and patient experience for a broader consumer base outside of its main campus.

Through community health system consolidation, Northwestern Medicine expanded its physician network. Northwestern acquired Lake Forest Hospital in 2010 and merged with Cadence Health Care in 2014.³⁹ The transactions provide the community health systems with access to Northwestern's specialty care. Northwestern benefitted by broadening its geographic presence and ambulatory locations outside of its primary service area, and solidifying its position with the regional payer market. With the addition of Cadence Health Care, Northwestern added a third more physicians to its network of over 1,000 employed physicians.⁴⁰

While the above examples describe AMCs' efforts to expand their physician networks, AMCs are also expanding their service offerings to be included in health plan narrow networks and protect referrals. One example is the launch of Vivity Health, a partnership among Anthem Blue Cross California, two AMCs (UCLA Health and Cedars-Sinai Medical Center), and five community health systems. The Vivity partners are focused on coordinating and improving care for patients in the Los Angeles and Orange County, California, market and on maintaining patient volumes by keeping patients within the partner health systems. They also intend to share financial risk.⁴¹ Other AMCs operate in the global health care market to protect patient referrals; an example is the University of Pittsburgh (UPMC) Global Care, which uses telemedicine and a virtual network of physicians to globally treat complex patients.⁴² UPMC Global Care also has regional locations in Ireland, Italy, and Singapore to oversee care.⁴³

Finally, many AMCs are expanding into retail health care on their own or via relationships with retail clinic chains. One of the largest chain of retail clinics has affiliate relationships with several AMCs. These offer the retail chain a referral location for complex patients. Little Clinic, a large chain of retail clinics owned by Kroger, has similar AMC relationships with Ohio State University Wexner Medical Center, and University of Colorado Hospital.⁴⁴ Mayo Clinic has several retail clinic locations throughout Minnesota and Wisconsin.⁴⁵



How can AMCs remain relevant and successful?

As market, financial, and regulatory challenges continue to grow, how can AMCs remain relevant and successful in the transforming health care marketplace? As illustrated by the examples in this paper, there can be broad benefits and positive outcomes for all parties when AMCs pursue consolidation with community health systems, physicians, and other providers. To determine if such consolidation may help them reach their strategic objectives, AMCs should consider market-specific strategies based on multiple relationship types — mergers, acquisitions, JVs, and more.

AMCs should also consider that challenges to consolidation may exist. For example, there is increasing regulatory scrutiny and financial barriers to undertaking M&A. Also, AMCs, with their unique culture and academic bureaucracies, may encounter difficulties integrating with community health systems and physicians. Fortunately, there are many AMCs which have successfully led consolidation efforts with community providers across the spectrum of relationship types and can serve as examples.

Looking to the future, AMCs may want to evaluate how they could use consolidation and other strategies to maintain and expand their research and education mission while mitigating competitive threats. Potential approaches may include:

- **Improving performance and benefiting the broader market by realigning care, including shifting lower-cost patients to community providers.**

As demonstrated by those AMCs which acquired a community hospital, performance can improve by building community-level relationships for referring complex patients to the AMC and shifting less-complex patients to community hospitals. Some AMCs may decide to minimize duplicative services at multiple locations and only offer certain services at lower-cost settings. This may also include a continued focus on outcomes and patient experience.

- **Diversifying revenue or expanding the network further by becoming a premium care provider or a diverse health company:** Recent successes with accountable care organizations (ACOs) and in population health management indicate that AMCs may be able to gain financial benefits from their expertise in quality and outcomes for high-cost patients – for example, financial incentives and bonuses through VBC contracts. Case in point: Montefiore Medical Center is an AMC focused on population health that has reduced costs as a Pioneer ACO. In addition, AMCs seeking performance improvements might consider options such as becoming health companies by offering more diverse offerings (e.g., retail health and wellness, health insurance plans) and integrated services.
- **Integrating with a larger health system, either by selling assets or divesting from a university.** Some AMCs may obtain the required resources for future growth by divesting from their universities and being acquired by or selling their assets to a larger health system. The University of Arizona Health Network's acquisition by Banner Health offered the AMC financial stability and access to capital.⁴⁶ Vanderbilt University Medical Center had a similar divestiture from its medical school to gain strategic flexibility to partner with community providers.⁴⁷

AMCs may develop multiple consolidation strategies for specific geographies and situations. Steps to identify the best path for AMCs to partner with community providers may include:

- Defining their objectives and aspirations;
- Understanding their market and financial positions;
- Assessing the various consolidation types;
- Identifying potential community partners; and
- Determining the best financial and governance model that benefits all participating organizations.

To navigate their journey to value-driven health care, AMCs will likely find that they can no longer go it alone. Rather, they may need to join forces with community health systems and physicians; an arrangement that offers broad market benefits and positive market outcomes.

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