Perspective on the University of Louisville Hospital Merger[1]

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Executive Summary

The proposed combination of the University of Louisville, Catholic Health Initiatives, and Jewish Hospital and St. Mary's HealthCare to (henceforth "CHI-Kentucky") reflects a powerful trend in the U.S. healthcare industry. There is an ongoing consolidation wave that dwarfs a similar movement that occurred in the 1990s. The resulting reconfiguration of the healthcare landscape will change how we obtain and pay for medical care.

The creation of CHI-Kentucky will give Louisville three competitive healthcare systems, including Norton and Baptist. Without this deal, the University of Louisville Hospital could lose access to Medicare and privately insured patients and face a dire financial future. But this merger poses some risks, especially because control of the hospital passes from a local board to CHI-Kentucky. The county and state should do all they can to assure that the hospital continues to deliver the same level of community benefit that it did prior to the merger.

Background on Consolidation in Healthcare

Healthcare providers have long believed that integration leads to lower costs and higher quality. During the 1990s, hospitals in urban areas formed integrated delivery systems (IDSs) by merging with nearby hospitals, acquiring primary care physician practices, expanding into ambulatory surgery, and even accepting "risk contracts" from health insurers that rewarded the IDS for cost savings but exposed them to financial risk if they failed to contain costs. The IDS movement sputtered for several reasons, including a lack of management information systems necessary to run a complex organization. Hospitals continued to merge throughout the past decade, albeit at a slower pace. In many cases these mergers were an effort to gain market power in order to increase reimbursements from health insurers.

Interest in integration has surged in the past two years, spurred on by three catalyzing forces. The first catalyst is the rapid proliferation of health information technology (HIT), exemplified by electronic medical records. HIT allows health care managers to integrate the healthcare delivery across the medical care process, potentially providing the kinds of management information systems that were missing in the 1990s. HIT is also essential if providers are to comply with new quality standards and pay-for-performance initiatives being imposed by Medicare and private insurers. The second catalyst is the unprecedented willingness of physicians to abandon the independent practice of medicine. This reflects several factors: (1)

[1] I was not asked to consider church/state issues when assessing the benefits and risks of this merger.

young physicians desire greater work/life balance and therefore are more willing to accept employment; (2) medical graduates are willing to take salaried positions to insure that they can repay their education debt; and (3) physicians cannot afford the high cost of adopting HIT and are willing to work in large organizations that provide an HIT platform for all of their members.

The third catalyst is the recently enacted Patient Protection and Affordable Care Act. A key provision of the Affordable Care Act calls for the creation of Accountable Care Organizations (ACOs). The best way to explain ACOs is to describe how they work. Imagine if CHI-Kentucky declares to the Center for Medicare Services (CMS) that it wishes to be an ACO. In order to implement the ACO provisions of the new law, CMS will track the utilization of all Medicare enrollees and "assign" to CHI-Kentucky those Medicare enrollees who receive at least half of their medical services from CHI-Kentucky providers. CMS will reimburse CHI-Kentucky for services rendered to Medicare patients throughout the year, much as it does today. However, at the end of the year, CMS will compare its spending on CHI-Kentucky "assigned members" against national norms.[2] If CHI-Kentucky can hold spending below national norms, it will receive a check from CMS equal to as much as 50 percent of the cost savings. If spending exceeds national norms, CMS may claw back from CHI-Kentucky as much as 50 percent of the excess. Through this "shared savings" program, CHI-Kentucky faces substantial incentives to contain costs. CMS has also established several dozen pay-for-performance standards for ACOs that can boost reimbursements by perhaps 5 percent or more.

If past is prologue, private insurers will soon follow Medicare and establish rules for paying ACOs. If this occurs, then nearly all U.S. healthcare dollars will begin to flow through ACOs.

Sensing this important change in payment patterns, hospitals are eager to form ACOs, with surveys suggesting that anywhere from 50-80 percent will be part of an ACO by 2015. Hospital executives planning to form ACOs believe that they must integrate horizontally (merge with other hospitals) and vertically (acquire physician practices) to be successful. Integration allows the ACO to maintain control over utilization, referral patterns, and HIT adoption and use. Through integration into primary care, ACOs will also share in the savings resulting from prevention.[3]

It is important to note that healthcare executives believe that they must keep as much patient care as possible inside their ACOs in order to control overall spending. Thus, hospitals that are not part of ACOs may be shut out of the Medicare and private insurance markets. I will return to this point below.

With these three catalysts for integration, markets are rapidly consolidating. Indeed, many metropolitan areas roughly the same size as Louisville are now dominated by only a handful of

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[2] Medicare enrollees do not formally sign up for an ACO, at least not under current rules. Thus, the concept of "membership" is based solely on the assignment rule described above.

[3] There is even ongoing discussion of regional consolidation (i.e., beyond a single metropolitan area) in order to rationally organize care delivery from local primary care to referrals into central city tertiary care centers. There is little evidence to date that this regional consolidation will be successful, but many providers seem eager to try. This is certainly an important aspect of the CHI-Kentucky system.

provider systems. Cleveland is dominated by the Cleveland Clinic and University Hospitals systems. Milwaukee has the Froedtert and Aurora systems and Pittsburgh has the University of Pittsburgh and West Penn/Allegheny systems. Some communities are dominated by just one system: St. Louis (BJC) and Boston (Partners) come to mind. The Federal Trade Commission is obviously concerned about the antitrust implications of such consolidation and has recently blocked several anticompetitive hospital consolidations. If consummated, the mergers that will create CHI-Kentucky would give Louisville three competing health systems: CHI, Norton, and Baptist. Thus, the Louisville market would be more competitive than many similar sized markets in other states. It is perhaps for this reason that the FTC did not oppose the deal.

Why this Deal is Good for University of Louisville, CHI, and Jewish and St. Mary's.

As a safety net provider, the University of Louisville Hospital relies heavily on three revenue streams to cover the losses it incurs treating the uninsured and Medicaid patients: Payments from private insurers, payments from Medicare,[4] and government subsidies. As discussed earlier, as hospitals consolidate into ACOs, those that are remain independent may be shut out of the Medicare and private insurance markets. If this were to occur to the University of Louisville Hospital, the financial consequences would be dire. Local taxpayers would be asked to make up for the losses incurred as good-paying patients migrate to other hospitals in established systems. There is no guarantee that the hospital will go down this path, but the possibility is too real to ignore. The formation of CHI-Kentucky takes the University of Louisville Hospital down a different path and likely prevents this financial catastrophe.

CHI and Jewish and St. Mary's also stand to benefit from this deal. Integrated systems must have tertiary care hubs to accept referrals of the most difficult cases. These patients require the most costly technology and the best skilled physicians. By establishing a referral hub, the system can avoid costly duplication of technology in member hospitals while improving outcomes. At the same, the system can get a leg up on negotiations with health insurers whose enrollees often value access to high quality teaching hospitals. The fact that CHI is promising to plough several hundred million dollars into University of Louisville Hospital suggests that it plans to make the hospital the tertiary care hub for the CHI-Kentucky system. This is good news for Louisville residents.

The Risks to the Louisville Community

This deal brings with it two important risks. The first is that the current consolidation wave might prove no more successful than the last one. By 2000, many systems were operating deep in the red and had to spin off the hospitals and physician practices they had acquired just a few years earlier. Thus, it is possible that the University of Louisville Hospital will be spun off in a few years time, having lost the opportunity to explore alternative strategic directions. With improvements in HIT, plus CMS' commitment to the ACO initiative, there is a much greater chance that integration will be successful this time around. Most industry executives believe this to be the case.

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[4] Medicare payment rates are below those for private insurance but remain high enough to cover the variable costs of care and contribute towards paying for fixed costs. Thus, all hospitals, including for-profit hospitals, remain eager to treat Medicare patients.

The second risk pertains to mission. The University of Louisville Hospital serves as the safety net hospital for the metropolitan area. Guided by a local governing board, the hospital is committed to admitting all patients regardless of ability to pay. It operates a trauma center and provides other services that give essential care to local residents and training to medical school students and residents. A trust that is funded by local government provides the hospital with approximately $35 million annually to defray the associated costs of these and other mission-related activities.

CHI-Kentucky will operate under Articles of Incorporation and control of the University of Louisville Hospital will be transferred to a board selected by the corporation. Although the corporation will be nonprofit, it will no longer be committed to the same mission as previously. Thus, CHI-Kentucky could choose to limit the number of uninsured and Medicaid patients treated at the University of Louisville Hospital, close down essential (but unprofitable) services, and instead use its excess revenues to fund other activities in Louisville and across the state. Although CHI-Kentucky would still need to provide community benefits sufficient to maintain its tax-exempt status, the concept of community benefits has proved "flexible" and many hospitals have maintained their tax exempt status without providing a level of charity care and other essential local services commensurate with the tax savings they enjoy as nonprofits.

Recommendations

Whether it proves successful or not, the merger wave is a reality and the University of Louisville Hospital will either find a merger partner or risk being orphaned. CHI-Kentucky appears to have the resources to create a competitive system in the Louisville market and establish the University of Louisville Hospital as the tertiary care hub of that system.

If the county and state approve the merger, they should do all they can to assure that the University of Louisville Hospital continues to pursue its mission as the safety net provider for the Louisville metro area. One possibility is to tie payments from the aforementioned trust to performance metrics such as levels of charity care. The county and state should explore establishing an independent, locally-controlled foundation that is responsible for funding certain mission-oriented activities of the hospital. This foundation would receive funding from the trust and from CHI-Kentucky. There is precedent for such foundations in situations where investors have acquired nonprofit hospitals and converted them to for-profit status, while relying on foundations to fund the historic charitable mission of the acquired hospital. Finally, the state should carefully review how nonprofit hospital meet the community benefit requirement for maintaining tax exempt status and work proactively with CHI-Kentucky to make sure that money does not come before mission.