



NEW PARTNERSHIPS FOR STRONGER MISSION

BY JOHN MORRISSEY

Catholic health organizations have been striking agreements to merge with new partners for several decades, but nothing like this. Not only has the pace of consolidation picked up, but the partners now frequently include non-Catholic entities, both not-for-profit and investor-owned. Health systems are actively staking out new territory while adding sites and services to areas they already occupy.

Behind the enthusiastically divulged details of each affiliation or merger are calculated campaigns to get bigger, broader and deeper, driven by government and market forces. For Catholic leaders committed to serving the vulnerable and marginalized, health reform requires that they undergo the metamorphosis of care delivery and payment structures needed to continue that commitment under the new norms.

The Affordable Care Act, its triggering of accountable care organizations and the introduction of insurance-type strategies, such as managing populations and bearing financial risk for their health, are responses to the runaway costs of health care. The resulting moves designed to live under this new norm are bringing to the fore efficiency and quality of care.

“We’re seeing the health care economy as unsustainable,” said John DiCola, senior vice president for strategy and business development at Catholic Health Initiatives (CHI), Englewood, Colo. “Unless Catholic health systems change, their ability to earn a margin

that allows them to reinvest in their communities, to maintain a standard of care, to meet the expectations of the residents of those communities — all of it is going to be threatened.”

Growth strategies have to weave health care quality into the fabric as they take shape. At PeaceHealth in the Pacific Northwest, for example, the strategic plan driving expansion is “to be able to integrate care and to deliver a level of quality and service at a much lower sustainable cost—with greater access, especially in underserved areas and those parts of the population who are most challenged,” said Peter Adler, senior vice president for strategy, innovation and development.

The changes that all health delivery systems, Catholic or otherwise, are seeking to make through strategic expansion are proliferating, but mainly

they revolve around:

- Operating more efficiently with less income, while investing heavily in evidence-based, prevention-oriented models of care and adapting to new value-based payment approaches.

- Becoming more attractive to payers and large employers looking to buy access to more effective, proactive and efficient care for their members wherever they live by assembling conveniently located, community-focused networks of care.

- Capturing a share of the anticipated new revenue on the horizon, such as fixed fees for bundled payment, expanded Medicaid coverage and subsidized private insurance for people who are poor or uninsured. For Catholic health systems, this is key to safeguarding and strengthening the mission going forward.

“Population health, IT infrastructure, quality oversight and so on, all of those are drivers,” said health care

Behind the enthusiastically divulged details of each affiliation or merger are calculated campaigns to get bigger, broader and deeper, driven by government and market forces.



consultant David Nygren. The fundamental challenge, however, “has to be whether or not the church can sustain [charitable] works into the future. And in order to sustain them, they need to focus on two things: one is going after new populations of human need, and the second is to be highly competitive.”

Nygren said it all comes down to being at least a certain size, perhaps \$4 billion or more in total assets and annual revenue. That’s what it will take to provide high quality health care at low cost while amassing the potential to generate revenue from sufficient covered lives. In order to better serve their populations and meet market demands, health systems also have to think big in a targeted way, assembling enough caregiving locations and varied services at a regional level to support both a comprehensive continuum of care and adequate access points in any given region.

“I see these very large systems in Catholic health care unifying, combining, focusing on success by merging with each other, collaborating within markets, getting out of markets where they won’t be successful — and they’re responding much more quickly than they might otherwise do because the federal health reform legislation is driving that kind of consolidation,” said Nygren.

Conversely, “the Catholic health systems that are spread across multiple states with a few

New demands to understand and manage populations are making scale all the more important.

hospitals here and there will not be successful. They’ve got to connect within market providers,” he added. “Many of our Catholic hospitals will not make this turn” because of insufficient density within a market, and in cases where they are “second- or third- or fourth-string players” in the markets they serve.

SIZE FACTORS

The original premise for system-building still holds: Some things can be done more efficiently in bulk and at a larger organizational size. “We do believe in economies of scale; we think the optimum economy of scale is at least \$3 to \$5 billion in

assets or annual revenues, and it might be larger than that,” said Jane Crowley, executive vice president for clinical integration and business development at Catholic Healthcare Partners, a Cincinnati-based system with \$4 billion in annual revenue and \$5.5 billion in assets. “We think that scale has enabled us to have the traditional advantages: low cost of capital, acquisition of talent, purchasing power.”

New demands to understand and manage populations are making that scale all the more important. “Part of what drives us at a national level in growing is the investment required in infrastructure,” said DiCola. “Information technology, insurance capabilities — insurance plans, potentially — really require a broader scale than any one regional system, or even systems of our size would be able to invest in successfully.” CHI’s operations in 19 states produce \$10.5 billion in annual revenues.

Those infrastructure investments are necessary to provide, for example, the different kinds of decision-making involved in new care-delivery models, including “data warehouses that allow us to understand a particular course of treatment or [how] a chronic disease is being treated, and tracking those outcomes so we learn from it and become better at managing population health,” DiCola said. New insurance services such as claims management and predicting future financial risk of certain populations, combined with strategies for staving off medical maladies, add up to “critical capabilities that require a different infrastructure than most systems have in place today,” he said.

Such sizable business and clinical needs propel significant consolidation opportunities, “certainly stand-alone hospitals looking for their pathway to the right partnership with a larger organization,” said DiCola. “We’re even seeing reasonably large regional systems — \$1.5 to \$2 billion systems — looking for larger national partners as they look at the investment required to create integrated networks, to create the new information infrastructure required to manage care differently and to build the insurance capability.”

The drive for size can’t happen in a vacuum, however. The motivation has to be the improvement of care at the local level, says Judith Persichilli, interim president and CEO of the new company being formed by the merger of Catholic Health East, Newtown Square, Pa., and Trinity



Health, Livonia, Mich. As the two systems combine, the strengthening of the financial foundation will help local ministries develop comprehensive services and market presence, she said.

“Systems do not deliver care. We deliver value to our local ministries,” said Persichilli. “And that

Scaling up in each community involves matching services to the medically and socially prevalent needs while staking out enough territory to cover all parts of the region.

value in this consolidation will be recognized through the synergies we realize from coming together.” Those include a single debt structure, improved risk management, better ability to score national contracts with payers and lower combined costs of supplies, information technology and employee benefits. The work to identify synergies will allow “the transactional work that we do that supports taking care of people to be delivered at the lowest possible cost. That brings value to the local ministries so that they can be prepared to develop the clinically integrated networks necessary to support population health.”

Indeed, the drive for size has to include a ground-level focus on building out an integrated continuum of care, region by region, said Crowley. Though Catholic Health Partners recognizes its size advantages, she said, “We don’t necessarily ascribe to ‘gigantic is better.’” The system and its advisers studied the effect of scale on financial performance over time and found that the degree of integration is the stronger variable. Regional powerhouses known for their high degree of integration such as Intermountain Health Care in Utah, Sentara Health in Virginia and Banner Health, based largely in Arizona, are “remarkably successful — [in] quality, community service and financial performance. They’re large, but they’re in the \$3 billion range” in annual revenue.

A regional or local focus is also the best for implementing the clinical performance improvement measures that can pay off in managing chronic illness, Crowley said. “The burden of chronic illness in this country is what’s driving health care inflation, and we know health care

inflation is what’s driving the federal deficit. And we know we can do better.”

REGIONAL CONCENTRATION

Scaling up in each community involves matching services to the medically and socially prevalent needs while staking out enough territory to cover all parts of the region. Health systems also are lining up their target territories with the way reimbursement opportunities are going to fall in the not-too-distant future.

“We’re spending most of our energy on advancing our integration and our presence in Ohio,” said Crowley. “Over the years, we have been pursuing market leadership in each community we serve, and we’re basically there. Out of seven markets, we’re first in five and close second in the other two in terms of market share.”

Looking at the way health care is financed, Crowley said, several issues point toward a statewide focus:

- Medicaid is state-operated, and “each state has a significant amount of authority and discretion over how its Medicaid program is structured.” A program just over the border can differ greatly.

- Health insurance is regulated at the state level.

- Large national payers mainly are organized by state — due in part to state-oriented regulation — with “some differences in how they contract and even with whom they contract.”

- Every state has a sizable government workforce that needs coverage, both current and retired.

Health systems seeking to position themselves for this environment need a statewide presence but not just in terms of general market share. “Even if you were the statewide leader, if you had only a 10 percent market share in some city, you’re not going to do very well,” said Crowley.

Adding to the state orientation is the addition of health insurance exchanges, or marketplaces, where millions of Americans will make decisions on health insurance starting in October. “A lot of people will go on that exchange and individually, one by one, select their health insurance,” she noted. The system’s aim is to bring the Catholic healing mission “to a large number of people

through that exchange.”

Persichilli said the regional strategies begun years ago by both Trinity and CHE figure into the synergies of the consolidation. The organizations “have worked really diligently with their local ministries to develop the footprint necessary to meet the complexities of health care reform — both with the realization that every geography is unique. So what we do in Camden, N.J., will perhaps be very different than Ann Arbor, Mich.”

These regional growth strategies follow from each community’s needs assessment. “In some areas, that could be an accountable care organization that is led by a clinically integrated network and able to take on risk,” said Persichilli. “In some areas, it may be changing significantly from an acute care to a home- and community-based model, where acute care beds are limited or perhaps exited totally, to bring value to a community.”

An important part of CHI’s strategy is to “build assets on a broader regional if not statewide basis across our landscape,” said DiCola. Over the years it has developed expansive health care networks in several states, including Kentucky, Iowa, Nebraska and Colorado, putting those areas in position to serve a broad enough population to develop either insurance products or payer partnerships that begin to change the payment model to value over volume, he said.

A health system can get to an overall size that it concludes is big enough and then concentrate solely on determining the right moves in its existing regions. St. Joseph Health, which serves defined areas of Southern California, Northern California and a region covering West Texas and eastern New Mexico, entered into an affiliation agreement with Hoag Memorial Hospital Presbyterian earlier this year to cooperate in serving vulnerable populations in and around California’s Orange County.

The decision “was not about growing in size; we’re very clear that we think we’re already of a size that allows us some of those economies of scale,” said Deborah Proctor, St. Joseph president and CEO. “We’ve adopted much more of a

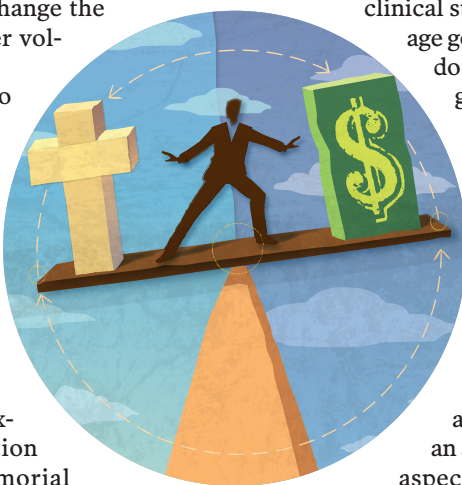
regional approach as opposed to a large-scale national approach.”

MISSION-ENABLING

The affiliation between four St. Joseph hospitals and Hoag in Orange County follows the faith-based motivations of many Catholic consolidation efforts today: business sense in the service of a moral, religious mission. “The church and its ministries are fundamentally missionary, and they are driven by real human need, first and foremost,” said Nygren. As a group, the 700-plus hospitals and associated health services operated by Catholic sponsors are responding the way they are to health reform because they want to preserve that Catholic ministry, he said.

The region covered by St. Joseph in Southern California has no public health system for the poor. “Because of that, there are a lot of people who fall through the cracks of health care,” said Proctor. Hoag had been equally concerned about this gap in care for those most vulnerable in the region, and the two competing systems had an affinity of vision over what was necessary to change that. A moral imperative motivated them to change the status quo by melding their complementary geographic coverage and combining clinical staffs to accelerate the coverage goals of each system. “You can do it alone, but you’re probably going to be less likely to create a very integrated system,” said Proctor. “We felt we could do it better together than we could do it alone.”

As in other instances of Catholic organizations seeking arrangements with non-Catholic, the transaction is planned as an affiliation that stops short of an asset transfer, while all other aspects of operation will be as a fully integrated system. It keeps the religious and ethical directives of the St. Joseph facilities intact and separate, but the affiliation in this case was driven by more than that, said Proctor. Hoag has “very involved sponsors who have created a very strong heritage and tradition there. All of the St. Joseph hospitals also have that. And we felt it was important that that not be lost.”





Catholic system growth in many areas of the country is involving non-Catholic entities because it's the only way to get to the size and concentration of presence necessary in the reform era, said Nygren. "Many of our founding ministries went to places that were unchurched, un-evangelized so to speak —untouched by the Catholic tradition," he said. Founding sisters went into these markets to establish outposts of care for minorities and Catholics, and "in many cases they are still the only Catholic provider in town — so with that, they're going to have to partner with non-Catholics."

Leaders of faith-based providers see the forces behind the proliferation of partnering — payment reform and the system-building to implement it — as a gain rather than a strain on the Catholic mission. "As Catholic providers, we see this drive for population health to be very mission-consistent and, in fact, mission-enabling, because putting patients at the center of our care model and extending compassion and the healing presence of Jesus is our mission," said Crowley. "And so we really welcome this change, because we think it will be more patient-centric and more compassionate."

And potentially better financially, Nygren added. The expansion of individual insurance coverage, and of Medicaid coverage for states that elect to take the ACA's offer to subsidize broader eligibility, "will allow [Catholic providers] to cover many, many more people in a highly successful way — and the risk associated with them — because the goal is to make people healthier," he said.

That won't come without some tension between the business and mission sides. Success depends on getting "the prime cut of the dollar" associated with as many covered lives as possible, Nygren said. "So you don't want just sick patients, you don't want just old patients, you don't want just poor patients. You want a large enough network to where you can average out your costs and still make money on the management of a population."

At the same time, a growth strategy "has to be mission-driven, and it really takes into consideration issues of the ethics of justice, that health care is a human right, caring for the poor," Nygren added. "If we only go after the slice of the dol-

lar that feds are going to pay for the wealthy and insured, that's not noble. So if our mission is going to remain noble, and we're going to be credible, we're going to have to work out large delivery systems that care for the entire population."

SO MANY APPROACHES

Conceptually the urge to merge is well-founded. In practice, the health care landscape is different everywhere, calling for a certain arrangement in one place that may fall flat somewhere else. "All of these partnerships are complicated for Catholic health systems," said Crowley. "Not just for CHP

Leaders of faith-based providers see the forces behind the proliferation of partnering — payment reform and the system-building to implement it — as a gain rather than a strain on the Catholic mission.

but for all Catholic systems, the degree of partnership even with individual physicians is challenging. And so that's why, in part, you see so many different approaches to it."

Just to consolidate two Catholic systems with similar histories and missions, teams from Trinity and Catholic Health East have been working more than a year to harmonize their already significant economies of scale for IT, supply chain and other functions for what's to come. And there's no assurance of what that may be. "We need to be prepared for just about anything," says Persichilli. "It's not going to be one way. And it's going to be different geography to geography, depending on what a particular community needs. We have to be prepared to take on risk, we have to be prepared to identify what our populations require, but at the end of the day, I don't think anyone has a really clear vision of what it may look like. So we make assumptions." One assumption is that health services have to be distributed outside the acute-care setting to move patients across different service levels communitywide, she said.

Tailor-made joint operating agreements (JOA) are coming into play more and more, to knit together regional health delivery, said DiCola. Over the years, CHI has used the vehicle to

develop a presence with logical partners. One example is Centura Health in Colorado, operated jointly with Adventist Health System. And recently in Kentucky, CHI created a JOA between its KentuckyOne Health — itself a merger of a Catholic and Jewish hospital in which CHI was part-owner — with University of Louisville Medical Center. That adds a new range of services, an

The latitude to go outside Catholic circles, and the size and financial stability it helps create, is in the end a positive force for Catholic priorities of service to the underserved, which the ACA is promoting.

academic affiliation and physician alignment in an arrangement that ties together the eastern and western parts of the state, DiCola said.

But in the nation's Northwest, an ambitious attempt to go beyond a JOA and form a new company turned out to be the wrong approach for CHI and its would-be partner, PeaceHealth. A letter of intent was announced in August 2012, but the deal was called off in April 2013. Carving out a portion of CHI's national network to create a 50-50 partnership with PeaceHealth posed problems for CHI such as debt funding and diminished supply purchasing power that could not be reconciled. CHI also had developed close relationships with the Catholic orders sponsoring health care in that region, including significant investment in scale and infrastructure, said DiCola. "How do you maintain some of those ongoing relationships and still respect the idea of creating a new entity?"

GETTING INTO A SYSTEM

For Catholic health providers seeking to gain the higher level of capital and economy of scale they now need to provide high quality health care more efficiently, governing boards are sorting through options ranging from national Catholic systems to secular not-for-profit networks or, increasingly, for-profit companies.

Loyola University Health System (LUHS), based mainly in the western suburbs of Chicago, chose to become part of Trinity Health in mid-2011 to shore up its financial outlook as well as align with the same Catholic mission, said Larry Gold-

berg, Loyola president and CEO. In a few short years, those signature services of health systems — access to capital, basic back-office expertise, strength in numbers — have put Loyola in position to compete in a 75-hospital market.

One immediate benefit of having Trinity as a parent is "its really strong corporate back-office functions that allow us to do better," said Goldberg. "From fiscal year 2012 to fiscal year 2013 [ended June 30], LUHS saw a \$100 million increase in operating revenue. That's just through good management and processes, and we were not profitable before that. The major reason we are profitable is that expertise."

Better financial stability is another positive. Loyola is "a big organization, but we're vulnerable to the economics of the state in our Medicaid programs," Goldberg noted. Hitched to a national organization, set to get even bigger when combined with CHE, "we pool that risk together so that we're a little bit immune to some of the pressures that we might feel here in Chicago."

Loyola also enjoys Trinity's Aa2 bond rating from Moody's Investors Service instead of the Baa3+ rating it merited on its own just before the consolidation. "This strengthens us and allows us to invest in things," such as a new electronic health record system for a community hospital in its network, Gottlieb Memorial Hospital. The cost of that system is part of a capital-budget spike: spending in the first year after consolidation was \$49.4 million, compared with \$19.3 million in the year before the consolidation.

Capital sufficiency was a prime goal of CharterCare, already a recent affiliation of a Catholic and secular hospital in Rhode Island, when it chose a national system in March to help it bulk up some more. But it picked a for-profit company, Prospect Medical Holdings, over other not-for-profit possibilities in a joint venture that, among other declarations, will preserve the "Catholicity" of Our Lady of Fatima Hospital, said Kenneth Belcher, CharterCare CEO.

CharterCare's three-year history — a consolidation of Roger Williams Medical Center and St. Joseph Health Services of Rhode Island — was a case of stellar performance but not stellar enough. "When we came together, we had said to the state that we anticipated taking roughly \$15 million of cost out of the system over the first five



years of our operations,” said Belcher. “We have taken just shy of \$30 million over the first three years, so we’ve doubled the amount in frankly half the time.” Clinically, “the quality scores of both hospitals continue to increase significantly” through use of best practices by a unified medical staff.

Despite the progress, “we’re not moving at the speed we wanted to move, particularly because of the challenge we had for capital,” Belcher said. Physician groups attracted by CharterCare’s recent track record were waiting for more assurance about the affiliation’s future — both finances and mission — before deciding to become part of its regional continuum of care.

A decade or more ago, the climate for Prospect would have been inhospitable in Rhode Island. In 1997 the state enacted one of the strictest hospital-conversion acts in the country, spurred initially by for-profit Columbia/HCA Healthcare Corp.’s attempt to acquire Roger Williams in 1996. But by 2012, the overriding issue had become financial viability of health care providers rather than their sponsorship, and the act was revised to eliminate provisions that were discouraging for-profit activity.

CharterCare will provide a competitive footing for Prospect, now operating in California and Texas, to expand to the East Coast, initially targeting Rhode Island and New Jersey, said Belcher. That introduces another for-profit player to an area that already includes Steward Health Care System, formed when the private equity firm Cerberus Capital Management made a capital investment in Catholic-sponsored Caritas Christi Health Care.

A POSITIVE FORCE

The latitude to go outside Catholic circles, and the size and financial stability it helps create, is in the end a positive force for Catholic priorities of service to the underserved, which the ACA is promoting. “Universal access is a basic tenet of justice under Catholic social teaching, so if we achieve something close to universal, we agree that would be a good result,” said Crowley. One prerequisite is the platform of access to ensure that attempts to cover more people do just that. Regional integration of willing partners, whether they’re from the area or looking to get in, begets revenue from health care purchasers attracted by what they see.

For St. Joseph and Hoag, said Proctor, “We now have a health system component in any part of the Southern California network where employers would have employees.” In its defined market of Orange County and the High Desert region, “we think it gives us geographic coverage that makes us appealing to both employers and payers.”

PeaceHealth’s 130-year ministry to a region from Oregon north to Alaska will get a lift from the incentives to aggregate providers, said Adler. The system continues to attract interest from secular not-for-profits with missions “very, very similar to ours — in many cases they are the sole provider in smaller markets, rural markets and isolated markets, or sometimes even in urban markets but in specific neighborhoods where they have been also committed for decades, some of them over a century, to serving all people regardless of their ability to pay.”

It’s a mutually beneficial dynamic, said Adler: The ability of those single entities to stay afloat in the current and predicted environment would be increasingly in doubt, and their entry into PeaceHealth’s sphere enables it to “get stronger and more stable as a result, because we’re able to spread our fixed cost for administrative services over a larger base.”

The drive for size amounts to a challenge for all Catholic health ministries, said Persichilli. “Can we strengthen Catholic health care overall — the structure of Catholic health care; the voice, particularly the advocacy voice for the vulnerable? ... Can our presence bring scale necessary, either in the local geographies or as a system, to [create] the economies of scale that will bring our cost of delivering care to its lowest possible level while still maintaining quality and safety at the highest level?”

Those are questions CHE is asking daily as it combines with Trinity. “If we are who we say we are, even with health care reform there will always be marginalized in our communities,” Persichilli said. “So keeping true to our faith-based mission to care for the poor, and having the financial foundation within which to do that, is our driving reason for seeking relationships with an organization that shares our vision and values.”

JOHN MORRISSEY is a freelance writer specializing in health care delivery, policy and performance measurement. He lives in Mount Prospect, Ill.

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, July-August 2013
Copyright © 2013 by The Catholic Health Association of the United States
