

October 2021

The Benefits of Integration: Healthcare in a Time of Rapid Transformation

A report by Kaufman Hall prepared for
the California Hospital Association

KaufmanHall

Executive Summary

Partnerships, affiliations, mergers, and acquisitions have been—and will continue to be—an essential tool for hospitals and health systems as they have worked to build integrated health systems that can respond and adapt to a rapidly changing healthcare landscape. Integrated systems make up a significant segment of today's care delivery system, and the growing complexities of the healthcare landscape require flexibility to continue to seek partnerships that preserve access to care in underserved communities, enhance the quality and affordability of care, and strengthen the resiliency of the healthcare system.

Integrated systems have brought many benefits to Californians and their communities, including the ability to:

- Form new partnerships that provide consumers with more options and better value as all healthcare organizations—hospitals, physician groups, health plans, and new entrants to the field—confront and respond to market forces far beyond what their traditional counterparts faced

- Preserve and expand patients' access to services and enhance the patient experience of care
- Drive quality enhancements and innovation in care delivery and payment models
- Reduce total cost of care by improving care coordination, increasing administrative efficiencies, and reducing capital expenditures
- Respond to public health crises such as the COVID-19 pandemic

Following a discussion of the transformative forces reshaping healthcare and a summary of the integration process in California today, this report will detail how integration has enhanced benefits for Californians in each of these five areas.

Whether a hospital or health system is the larger or smaller partner in a decision to integrate, that decision is never made lightly. Integration requires a tremendous amount of effort to execute successfully. But as demonstrated in this report, the many benefits to patients and communities that a successful integration can provide make the effort worthwhile.

Transformative Forces Reshaping Healthcare

Healthcare in the United States, and in California, has transformed. Any assessment of the benefits and potential drawbacks of integration must recognize that integrated systems make up a significant segment of today's care delivery system and additional restrictions on the ability to integrate will come with significant losses in access, quality improvement, and cost efficiency. Analysis must look to the future, not backward to an environment that no longer exists.

Integration has been a critical tool that hospitals and health systems have used to preserve or expand patient access to care, build attractive, high-quality networks and service portfolios for patients and health plans, attract the intellectual talent needed to create innovations in patient care, increase scale to spread the benefits and costs of innovation across a broader base, and reduce total cost of care by eliminating redundancies and duplicative services. The COVID-19 pandemic has demonstrated another public health advantage of integration, as larger systems have been able to quickly deploy resources to facilities where needs are highest and better coordinate care for patients who have required hospitalization.

Transformation of healthcare has been driven by multiple forces. Even before the COVID-19 pandemic struck, changing demographics, innovations in care delivery, and the emergence

WHAT IS INTEGRATION?

Integration results from the range of partnerships, affiliations, mergers, and acquisitions that healthcare organizations use to expand healthcare services into new communities, preserve healthcare services in underserved communities, gain access to the capital and other resources needed to improve the patient experience and quality of care, build viable care delivery networks for health plans and local employers, and ensure the financial sustainability and long-term viability of essential healthcare resources. Integration combines the resources, capabilities, and expertise of distinct entities to create an entity better positioned to achieve these goals.

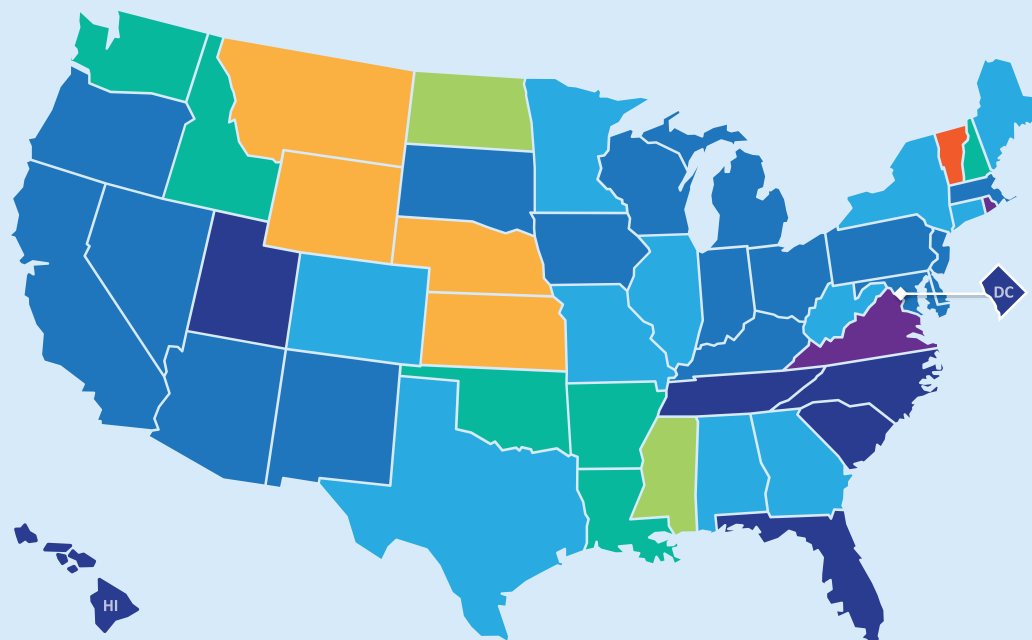
of new entrants to the healthcare market—from large national chains such as CVS Health and Walmart to tech-focused start-up companies—were challenging the financial sustainability of many hospitals and health systems and their ability to provide high-quality, affordable, and accessible care to their communities. Many of these organizations have already successfully integrated with larger health systems to survive

amid these sweeping dynamics, often with broad community support.¹ American Hospital Association (AHA) data shows that 67% of community hospitals nationwide (3,453 of 5,141) were already in a system as of 2019, the most recent year for which data is available. In California, the percentage was 72% (259 of 359 community hospitals). Only eight states had fewer than 50% of their community hospitals in a system.²

Percentage of U.S. Community Hospitals in a System as of 2019, by State

In almost 80% of the most highly integrated states—and in California—the average total annual premium costs for an employer-sponsored single individual health plan were *below* the national average in 2019.

Kaiser Family Foundation,
State Health Facts



LEGEND

90% or more
80%–89%
70%–79%
60%–69%
50%–59%
40%–49%
30%–39%
Fewer than 30%

Source: American Hospital Association, *Fast Facts on U.S. Hospitals*, 2021

There is no apparent correlation between higher levels of integration and lower levels of affordability for consumers; in fact, **consumers in more highly integrated states may have more affordable insurance premiums and lower per capita healthcare expenditures.**³ Consumers experience healthcare costs primarily through the cost of insurance. The Kaiser Family Foundation's 2019 data for the average annual single premium per enrolled employee for employer-sponsored insurance (the main source of individual health plans for consumers) shows that almost 80% (7 of 9) of the most highly integrated states identified by the AHA data had total annual premiums *below* the national average of \$6,972 (California was also below this average). In comparison, 50% of the least integrated states had total annual premiums *above* the national average.⁴ Similarly, the most recent data on per capita health expenditures by state shows that two-thirds (6 of 9) of the most highly integrated states have expenditures *below* the national average of \$8,045 (again, California also is below this average). In contrast, more than 80% (5 of 6) of the least integrated states have expenditures *above* the national average.⁵

The nature of many healthcare organizations has changed rapidly as well. Health systems have aligned with health insurers to develop coverage tailored to patient needs in their markets. Independent physician groups are running their own ambulatory surgery centers and have partnered with health plans and health systems to create

new care networks. Retail-based clinics—such as those located in national drugstore chains or big-box retailers—have partnered with health systems, large physician groups, and health insurers to expand points of access to care.

These changes appear to be embedded in the long-term healthcare landscape, even as the COVID-19 pandemic has introduced new pressures, some of which accelerate preexisting trends and some that reverse gains made in recent years. For example:

- UCLA Health reports that telehealth in its department of medicine went from less than 1% of visits to 55% in less than 50 days (from March 9 to April 18, 2020). Since then, telehealth visits have leveled off at 25% and are “likely here to stay.”⁶
- After experiencing several years of declining enrollment in Medicaid programs, all 50 states experienced increased enrollments in 2020, with an average national increase of 8.6% (just under 5% in California).⁷ The most recent American Hospital Association data shows hospitals received only 90 cents for every dollar spent caring for patients in 2019.⁸
- A new federal program has begun delivering vaccines directly to retail pharmacies—including CVS Health, Walgreens, Walmart, and Kroger—to take pressure off health systems already overwhelmed by treating COVID-19 patients.⁹

- COVID-19 has accelerated the tech sector's dominance across multiple fields and could drive new, powerful entrants into the healthcare space. Apple's market capitalization rose from \$1 trillion to \$2 trillion between March 2020 and August 2020 (by comparison, it took Apple 38 years to get to \$1 trillion). Amazon's revenue was up 40% in the second quarter of 2020. Both companies (along with others, such as Google) have entered the healthcare field: Amazon, for example, recently expanded its app-based Amazon Care digital health platform to 21 states.¹⁰
- The pandemic has raised new questions about the fee-for-service structure of healthcare payments as hospital, health systems, physician groups, and other healthcare providers were hit by severe drops in volumes and revenues in the face of shutdowns and consumer reluctance to enter provider facilities during the pandemic. The pandemic may well result in accelerated movement toward capitated or global payment structures in which healthcare organizations assume risk for the health of attributed populations.

In short, how and where consumers receive care have changed dramatically; new entrants to the healthcare field have strengthened their footing; the pandemic's economic toll has shifted the payer mix at hospitals from commercial insurance to government programs; and an accelerated move toward risk-based global payment models is likely.

EXTERNAL PRESSURES DRIVE INTEGRATION

Integration is needed to respond to the many pressures health systems face:

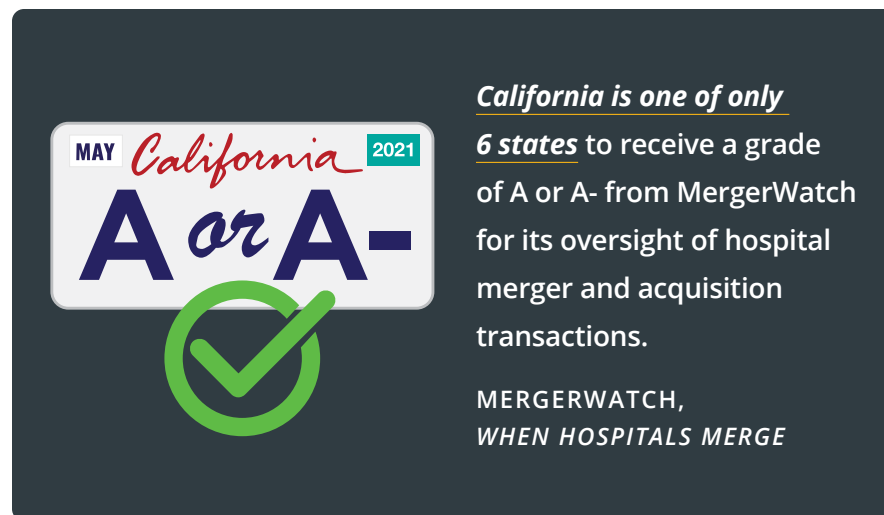
- As health systems are asked to assume risk for patient populations under capitated or global payment structures, they must be able to manage patient populations that are big enough to diversify risk, which allows the health system to absorb the impact of high-cost, high-risk patients on system resources.
- As the percentage of Medicaid and Medicare patients grows, health systems must have the financial resources to weather below-cost payments from these programs and the ability to drive down costs through efficiencies of scale.
- Expansion of telehealth and retail outlets for healthcare has introduced competition from national retail companies and tech giants whose scale and resources dwarf those of the largest health systems. Integration and increased scale help health systems access the financial and intellectual capital they need to remain competitive and continue to provide the acute-care and specialized services on which the communities they serve depend.

Hospitals and health systems must have flexibility as they continue to adapt to the growing complexities of the healthcare landscape. In the words of Tom Priselac, CEO of Cedars-Sinai, integration strategies, and the policies that affect them, “cannot attempt to drive forward while looking in the rearview mirror.” The future of healthcare, and the resources hospitals and health systems will need to thrive in the future, must be the focus. Integration has already demonstrated many benefits to California patients and communities and the ability to maintain and enhance these benefits is what drives integration strategy today.

Integration requires tremendous effort from the health system or hospital partners, who in California already face one of the strongest integration oversight processes in the nation.

Whether a hospital or health system is the larger or smaller partner in a decision to integrate, that decision is never made lightly. Integration requires a tremendous amount of effort to execute successfully, and factors such as organizational culture or unexpected costs discovered during due diligence can make or break a transaction.

Kaufman Hall has identified 46 integration transactions between hospitals and health systems that have successfully closed or are pending in California since 2009; an additional 14 transactions were cancelled by one or both of the parties. The reasons for cancellation



were diverse, including differences in mission and strategic vision, unanticipated costs of rebuilding an electronic health record (EHR), failure to secure adequate resources to close the transaction, and action by state agencies. Despite the many difficulties inherent in the integration process, however, the many benefits to patients and communities that a successful integration can provide make the effort worthwhile.

California is already one of only six states to receive a grade of A or A- from MergerWatch for its oversight of hospital merger and acquisition transactions (see sidebar, “Integration Oversight in California”).¹¹ Policymakers should never cede their oversight of

INTEGRATION OVERSIGHT IN CALIFORNIA

All hospitals seeking to integrate are subject to pre-transaction notification requirements established by the U.S. Department of Justice and Federal Trade Commission, the federal government's two antitrust enforcement agencies. California hospitals also are subject to additional state oversight:

Pre-Transaction Review by the California Attorney General

- Virtually all not-for-profit hospitals seeking to integrate must receive the approval of the California Attorney General. The review period lasts 90 days, but the Attorney General can extend that period for 45 days if certain conditions are met and can request even longer extensions of the review period with the consent of the parties involved.
- The Attorney General can approve, conditionally approve, or deny the proposed transactions. It is the Attorney General office's policy to require continuation of annual charity care costs and maintenance of existing levels of essential healthcare services, including emergency room services, for at least five years as conditions for a proposed transaction.¹² Additional conditions are often required, typically for a number of years following the transaction, and may include such items as continuation of specialty services (e.g., trauma, women's health, or neonatal intensive care), maintenance of current medical

staff privileges, ongoing participation in Medicare and Medi-Cal, or capital investment requirements.

- The Attorney General has full powers to enforce any of the conditions required for approval of the transaction.
- Approval of a transaction is at the discretion of the Attorney General. Although California is one of the highest rated states in terms of its overall oversight requirements, as scored by MergerWatch, it receives a lower score on its organizational structure for review because it relies so heavily on the Attorney General's discretion.

Additional Attorney General Powers

- The Attorney General has the authority to challenge in court *any* healthcare transaction (whether not-for-profit or investor-owned), regardless of whether that transaction has been approved by another state agency. These challenges can be made either before or after the transaction has occurred.

Private Party Challenges

- Private parties—including large and sophisticated health insurers and employer groups—can also challenge in court the alleged anticompetitive effects of a transaction under California state law (e.g., the Cartwright Act, Unfair Practices Act, and Unfair Competition Law).

integration, in healthcare or in any other field, but they also should not place undue burdens on organizations whose mission is to preserve and enhance access to care, drive quality and innovation in care delivery, expand the choices available to patients in their local communities, and reduce the total cost of care through improved efficiencies and better coordinated care delivery and care protocols. Integration was necessary to improve—and will remain necessary to the continued improvement of—the accessibility, affordability, and quality of healthcare for all Californians and their communities. A discussion of five key benefits of integration follows.

“We cannot attempt to drive forward while looking in the rearview mirror.”

TOM PRISELAC, CEO, CEDARS-SINAI

Key Benefits of Integration

- 1 Integrated health systems are positioned to form new partnerships that provide consumers with more options and better value. Whether it's hospitals, health plans, independent physician groups, or new market entrants, organizations are confronting and responding to market forces far beyond what their traditional counterparts faced.**

Hospitals and health systems operate today within a complex healthcare landscape.

Health system revenues are now evenly divided between inpatient and outpatient services.¹³ Outpatient services are offered not only by health systems, but also by independent physician practices and physician-owned ambulatory surgery centers, which do not bear the carrying costs of general acute-care hospitals, including 24-hour operations, support of emergency departments (including the obligation to provide care to anyone seeking emergency services, regardless of ability to pay), specialty services such as transplants and trauma care, high-cost medical equipment and specialized clinical staff, and federal and state regulatory compliance. Retail-based health centers—including CVS Health, Walgreens, and Walmart—are offering a widening range of primary care and chronic care management services, also without the carrying costs of general acute-care hospitals. To survive, hospitals have been

“Now that we have three hospitals and increased capacity, we can repatriate our managed care patients within our health system, saving millions of dollars we had to spend on care delivered outside our system.”

PAUL LORENZ, CEO, SANTA CLARA VALLEY
HEALTH AND HOSPITAL SYSTEM

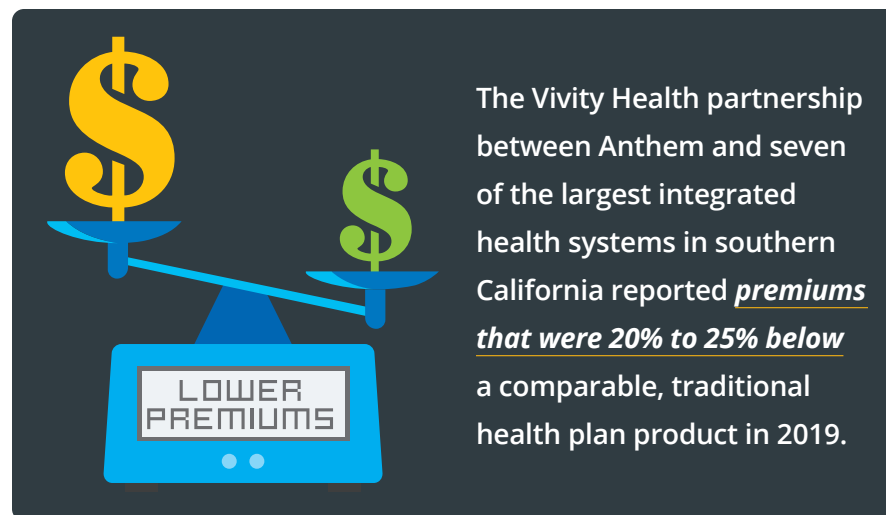
adapting to shifts in the settings where healthcare services are utilized in order to survive and are actively seeking partnerships that provide greater choice and affordability to consumers.

The enhanced resources and expanded population base that integration provides helps hospitals mitigate their high cost burden and provide more accessible and affordable services. For example, Santa Clara Valley Health and Hospital System, which

recently acquired two hospitals and a health clinic from Verity Health System, noted that its larger footprint will enable it to provide new specialty services that are currently offered only by a single independent physician practice, offering greater choice and affordability to consumers in its market.

The line between hospitals, traditionally the provider of care, and health plans, traditionally a buyer of care, also is blurring. This reality was recently acknowledged by a U.S. district court ruling in Pennsylvania.¹⁴ The largest insurer in the market testified against a proposed merger of two health systems in Philadelphia. The court noted that this insurer “had a clear motive, other than antitrust concerns, to oppose this merger.” The insurer was concerned that the merged health systems would “be a potential competitive threat as an insurer.”

The health systems in the Pennsylvania case were actively working with other insurers to develop new health plans that would provide consumers more options and greater affordability; this, the judge indicated, was the source of the largest insurer’s opposition to the merger. What was true in Pennsylvania is true in California and across the country: health plans and integrated health systems are moving away from an historically adversarial relationship to partnerships in which both entities work together to provide new health plan options



that give consumers access to quality care at a lower cost. Most consumers experience the cost of healthcare primarily through the premiums, deductibles, and copayments for their health plan. Health plans and integrated health systems are partnering to economically align their interests in the service of the consumer.

For an integrated health system, an attractive health plan partner has a sufficient member base to help support the health system’s services at a *lower cost per unit*, as services can be offered most efficiently when the high fixed costs of specialized clinical staff and inpatient beds can be spread across a higher number of

procedures.¹⁵ For a health plan, an integrated system with the resources to fund care delivery innovations and support the range of services its members need to access is the most attractive partner.

California, of course, has been a longstanding national leader in demonstrating the value of integrated health plan and care delivery systems through organizations such as Kaiser Permanente and Sharp HealthCare. New partnerships between health plans and integrated health systems are now demonstrating their value as well. Vivity Health, a partnership between Anthem and seven integrated health systems in Southern California, reported that premiums for its health plan in 2019 were *20% to 25% lower than*

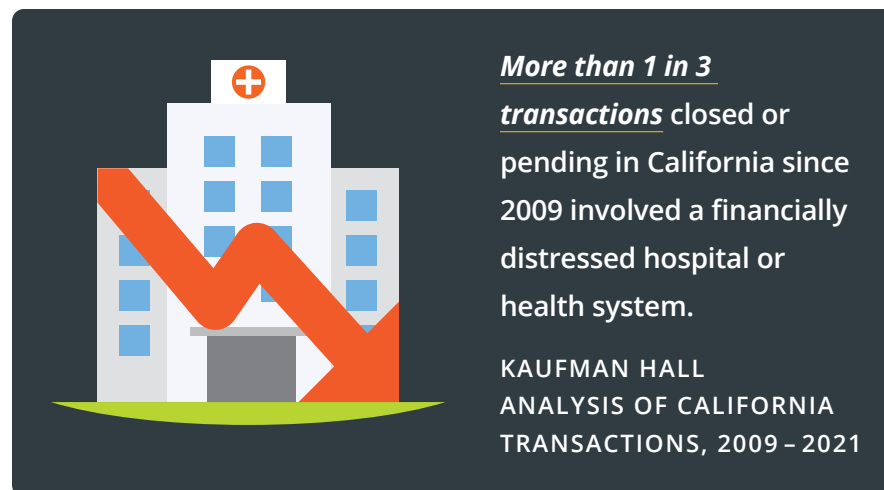
*a comparable, traditional Anthem health plan offering.*¹⁶ In Northern California, UnitedHealthcare has partnered with Canopy Health—a network of integrated health systems and physician groups—to create a portfolio of health plan products that could save consumers up to 25% in premiums.¹⁷

Integration gives health systems the ability to recruit and fund thriving specialty practices, and to partner with health plans on attractive and affordably priced new consumer options. In doing so, integrated health systems strengthen the accessibility, affordability, and choice of care offered to consumers in increasingly complex healthcare markets

2 Integration supports health systems' mission of benefiting patients and their communities.

A significant driver of the decision to integrate for some smaller, independent hospitals is the difficulty of remaining financially viable in today's challenging operating environment. Financial struggles can affect the ability to recruit clinical staff, invest in or upgrade technology and equipment, and fund the full range of services (including high-cost specialty services) needed by the community. In the most extreme cases, communities may face closure of facilities. Kaufman Hall has identified 46 partnership, merger, or acquisition transactions in California since 2009 that have successfully closed or are pending; of that number, more than one-third of the transactions (16) involved a financially distressed hospital or health system.¹⁸

Integration can produce significant improvement in the services financially struggling hospitals can provide to their communities. Six years ago, ValleyCare Health System, a community-owned, single-hospital health system in the East Bay area found itself in desperate need of a capital partner: in the words of John Sensiba, chair of the ValleyCare board at the time of the merger, "the ability to *have* a hospital was the driver of the decision to integrate."



ValleyCare found a partner in Stanford Health Care—a partnership that was **approved by 97% of ValleyCare's community owners**—and the resulting turnaround has been dramatic.

Stanford ValleyCare was able to introduce an EHR, enhance the medical expertise of its clinical staff, and introduce new service lines, including a stroke program that has now developed into a center of excellence. Bob Shapiro, who has served as chair of the

charitable foundation charged with oversight of the California attorney general's conditions for the merger, notes that "confidence in the healthcare system is at an all-time high. There is a sense of pride in the healthcare system, and a sense of safety and security."

In March 2020, **92% of voters** in Mendocino County approved a partnership between a local public hospital—Mendocino Coast District Hospital—and Adventist Health, a faith-driven healthcare system based in California. The critical access hospital was facing a rocky financial future. For Adventist, with its deep experience operating rural hospitals, this was a way to make sure the residents of the northern California coast could continue to get the healthcare services they need close to home. The partnership is benefiting both patients and the community:

- Healthcare services are being kept local, a stark change from a time when residents were driving as far as 70 miles away for care
- New specialties have been made available, including orthopedic, gastrointestinal, and cardiac care; residents now have access to 32 newly recruited physicians
- Travel nurses have been replaced with permanent, locally hired nurses, providing a boost not only to healthcare services, but also to the local economy of a struggling region

"O'Connor Hospital had about 50,000 emergency department visits each year, and St. Louise Regional Hospital had 25,000 to 30,000. If these hospitals closed, where would these emergency cases go? The hospitals needed to stay open to meet the needs of the community."

PAUL LORENZ, CEO, SANTA CLARA VALLEY
HEALTH AND HOSPITAL SYSTEM

- Collaboration will drive healthcare services forward; already, 68 units of affordable multi-generational housing for workforce, seniors, and transitional living is being built right next door to the hospital, enabling seniors to readily get the care they need and stem some of the outward migration from the county
- A population health management approach will foster enhanced wellness and preventive medicine, to help keep people healthy *before* they need hospital care
- Clinical specialists rotate through several Adventist facilities in the county, providing access to those who need it closest to home
- Significant efficiencies are being realized by consolidating IT services and management and sharing health information to reduce redundant services

In November 2020, **85% of voters** in Sonoma County approved the sale of Petaluma Valley Hospital to Providence St. Joseph Health and the sale was finalized in January 2021. The hospital had struggled for years with limited funding and was in dire need of infrastructure repairs; without action, the hospital could have faced closure. Now, nearly 400 employees who faced an uncertain future have been provided with stability and job security and needed infrastructure repair—including millions of dollars for seismic compliance, a new roof, new boilers, and replacement of other aging equipment—can begin.

Long-struggling St. Francis Medical Center in south central Los Angeles received a much-needed lifeline when the U.S. Bankruptcy Court for the Central District of California and the California Attorney General approved Prime Healthcare's purchase of the hospital on August 14, 2020. Through a focus on local hiring, Prime Healthcare has been able not only to stabilize jobs for 2,000 St. Francis employees, but also to support local subcontractors and businesses. Patients have benefited as well: For example, St. Francis has expanded its behavioral health capacity by 60%, enhanced its cardiology and radiation oncology services through new clinical capabilities, and, through new partnerships with Children's Hospital

"Confidence in the health system is at an all-time high. There is a sense of pride in the healthcare system, and a sense of safety and security."

BOB SHAPIRO, CHAIR, STANFORD VALLEYCARE
CHARITABLE FOUNDATION BOARD

"There are over 50,000 people who live in Petaluma Valley. It would be hard to imagine a community of that size without an emergency department...without a local hospital of their own."

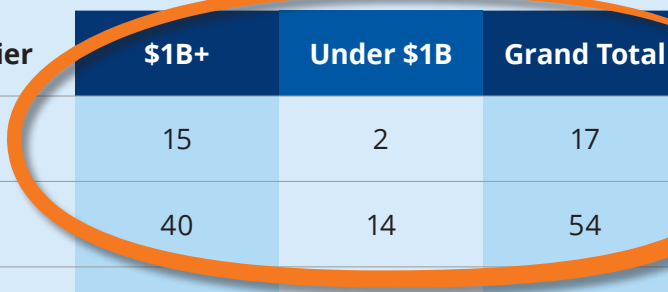
ERIC WEXLER, CHIEF EXECUTIVE OF PROVIDENCE
ST. JOSEPH HEALTH SOUTHERN CALIFORNIA

of Orange County and UC Irvine Health, brought neonatal clinicians to residents of Lynwood and the surrounding neighborhoods, keeping patients closer to home and improving maternal health in the communities St. Francis serves.

The benefits that integration with a larger system can bring to patients and communities is reinforced by the results of a national survey by Kaufman Hall that scored hospitals and health systems across four areas of consumerism: access, experience, pricing, and infrastructure.¹⁹ Based on these scores, organizations are assigned to one of four tiers. Organizations in Tier 1 are best-in-class, while those in Tier 4 lack meaningful movement toward consumer-centric strategies across the four areas.

In an analysis of the underlying survey data, Kaufman Hall has determined that 43% of the survey respondents at organizations with annual revenues in excess of \$1 billion were in Tiers 1 and 2, while just 17% of organizations with revenues below \$1 billion were in these tiers. At the highest level, 15 of the 17 Tier 1 organizations had revenues above \$1 billion. In other words, the larger health systems with revenues in excess of \$1 billion are almost all *integrated health systems that are able to devote greater resources to improving the patient experience.*

Ranking of Systems' Consumerism Performance by Size (Annual Net Patient Service Revenue)



Overall Tier	\$1B+	Under \$1B	Grand Total
1	15	2	17
2	40	14	54
3	48	38	86
4	23	42	65
Grand Total	126	96	222

Source: Kaufman Hall, survey data for 2019 *State of Consumerism* report.

The Stanford ValleyCare example illustrates an important trend in integration: the expansion of the academic medical center's trifold mission of clinical care, research, and teaching into communities outside the main metropolitan core where academic medical centers are typically located. Some examples of the benefits derived from this model include:

- Santa Clara Valley Medical Center, through an affiliation with Stanford, will now be able to offer rural health residencies at Gilroy's St. Louise Regional Hospital, acquired following the bankruptcy of Verity Health System.
- During the pandemic, Stanford ValleyCare's academic affiliation enabled it to be among the first hospitals to host trials of remdesivir for the treatment of COVID-19.
- The joint venture between Cedars-Sinai and Providence Health System to invest in Tarzana Medical Center will bring enhanced specialty services, including a cardiology center of excellence, to the San Fernando Valley and enable more patients to receive pre- and post-surgical services locally.
- Physicians affiliated with Tarzana Medical Center will be able enhance their clinical expertise through continuing medical education courses offered through Cedars-Sinai.

"With 92% of voters approving the affiliation, I think the community saw our mission clearly. They saw our credibility, our work with underserved populations. They saw an organization that has the resources to provide stability to a hospital that might have been in for some tough times. They saw our ability to keep care local. And they voted the way they did because these are values they care about. They are the same values Adventist holds at the top of all we do."

SCOTT REINER, CEO,
ADVENTIST HEALTH

3 Integration is a driver of quality and innovation.

The link between higher volumes and improved clinical outcomes is well established. The Leapfrog Group, one of the nation's leading authorities on hospital quality and safety, has listed eight high-risk procedures for which there is a strong volume-outcome relationship, noting that:

Three decades of research have consistently demonstrated that patients that have their high-risk surgery at a hospital and by a surgeon that have more experience with the procedure have better outcomes, including lower mortality rates, lower complication rates, and a shorter length of stay than for patients who have their surgery done at a hospital or by a surgeon with less experience.²⁰

This relates directly to the value of integration as integrated systems that cover a broader population base also will have higher volumes of most medical and surgical procedures. A quality-focused integration strategy often involves creation of centers of excellence based upon access to a broader patient population. For example, since Cedars-Sinai and Torrance Memorial Medical

"Our affiliation with an academic medical center allowed us to bring nationally ranked programs to our South Bay community. Our patients have benefited from our ability to offer a spectrum of advanced procedures that were never previously available in our market and to provide a more advanced level of care within the community."

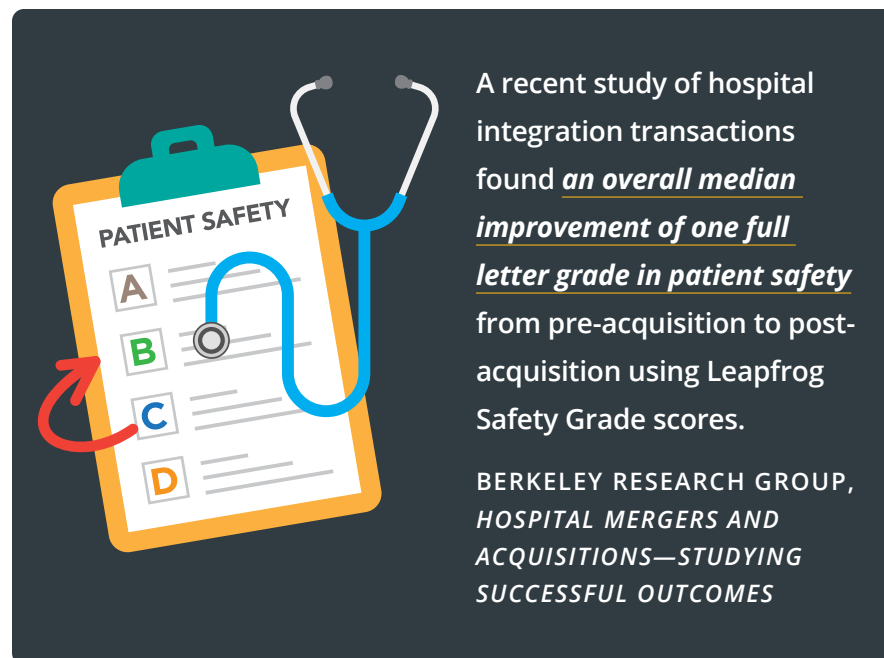
CRAIG LEACH, PRESIDENT AND CEO,
TORRANCE MEMORIAL MEDICAL CENTER

"There's an important balance between physician autonomy and affiliation with a system. It's great to have a partner who can come up with good practice guidelines based on academic research that benefit both the patient and the physician. I went into medicine to take care of people, and I think integration can help us in that regard."

JEFF WORK, INDEPENDENT PHYSICIAN, CARDIOLOGY
CONSULTANTS MEDICAL GROUP, TARZANA

Center finalized their affiliation in 2018, patients have benefited from greater access to specialty services and a higher level of care at Torrance Memorial. The affiliation has enabled Torrance to achieve comprehensive stroke center designation, which indicates that it is among the best-equipped hospitals to treat any kind of stroke or stroke complication. In addition to advances in neurosciences, Torrance Memorial has also been able to expand capabilities in thoracic surgery, cardiovascular surgery, cancer, and clinical trials. The Medical Center has seen increased volume for these services and OSHPD data suggests that since the affiliation, a greater volume of advanced-level patients²¹ have been able to stay in their community for services. The number of OSHPD-defined advanced level patients at Torrance Memorial has grown from 1872 in 2017 to 1922 in 2019. At the highest level of care (patients with a DRG of 6+), the number of patients has grown from 258 in 2017 to 341 in 2019, a 32% increase.

A recent report on hospital and health system integration transactions over the past five years supports the role of integration in improving the quality of patient care. Using the Leapfrog Safety Grade as a proxy for quality, the report found an overall median change of one full grade (i.e., from “C” to “B”) from pre-acquisition to post-acquisition, with 71% of the studied transactions achieving improvement of at least one full grade.²²



A recent study of hospital integration transactions found an overall median improvement of one full letter grade in patient safety from pre-acquisition to post-acquisition using Leapfrog Safety Grade scores.

BERKELEY RESEARCH GROUP,
HOSPITAL MERGERS AND
ACQUISITIONS—STUDYING
SUCCESSFUL OUTCOMES

At CommonSpirit, the health system formed in February 2019 through the integration of Dignity Health and Catholic Health Initiatives, the ability to leverage best practices and clinical expertise from hospitals across the country has fueled significant improvements in quality and patient safety. For example, the health system has improved from the 65th to the 81st percentile in treatment for sepsis and from the 49th to the 59th percentile in reduction of *c. difficile* infections.

Integration can also help drive innovation in both payment models and care delivery. Academic medical centers, for example, face difficulties participating in risk-based payment models because they treat the “sickest of the sick”— patients who at most hospitals would be outliers in terms of the length of care and intensity of resources needed for their treatment. The Association of American Medical Colleges and the Healthcare Financial Management Association recently studied the financial and clinical impact of transfer patients on major teaching hospitals. Transfer patients are those who start their care at a hospital other than the teaching hospital, but because of the severity of their illness, need specialized services or an intensity of care that the original admitting hospital cannot provide. The study found that, in comparison with patients originally admitted to the teaching hospital, *transfer patients had a higher length of stay, a higher average case severity, and both higher average costs per case and costs per day.*²³

Integration of academic medical centers and community hospitals provides lower cost sites of care for treatment of patients who do not need the intensity of care that the main academic campus can provide. At Stanford Valley Care, for example, the hospital has

“Our mission is to care for the poor and vulnerable. Regardless of their ability to pay, patients in the San Fernando Valley who seek care at the Providence Cedars-Sinai Tarzana Medical Center will receive care as good or better than what they could get by driving ‘over the hill’ to hospitals in Los Angeles.”

BERNIE KLEIN, INTERIM CEO, PROVIDENCE CEDARS-SINAI
TARZANA MEDICAL CENTER

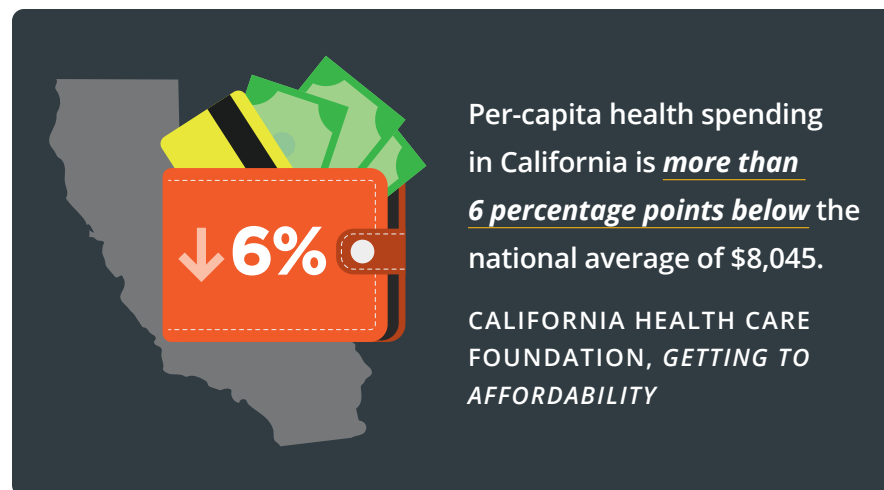
been able to pilot bundled payment programs (where the hospital receives a single payment, benchmarked to average historical costs, for an entire episode of care) that would be difficult to pilot at the main Palo Alto campus, where patients requiring the highest intensity of care are treated. The use of lower-cost sites of care for lower-acuity patients also reduces total cost of care across the health system. At the same time, with academic medical faculty sharing their expertise across the health system, patients benefit from innovations in care protocols and care delivery *regardless* of their site of treatment within the system.

4 Integration can reduce total cost of care.

Significant integration has already occurred in California, and the state remains in an enviable position for total cost of care in comparison with nationwide averages. The California Health Care Foundation's 2020 report on *Getting to Affordability* cited pricing and market inefficiencies as one of six factors that contribute to wasteful healthcare spending. The report acknowledged, however, that "average health spending in California is lower than in the rest of the country by some measures," with per-capita health spending in California (\$7,549) more than 6 percentage points below the national average of \$8,045. The report also noted that employer health insurance premiums in California were below the national average.²⁴

There are several ways in which integration can reduce cost of care, including:

- **Increased administrative efficiencies.** Integrated systems can centralize support functions such as finance, IT, and human resources and spread the cost of these functions across a greater number of facilities. A study of hospital integration



transactions completed between 2000 and 2010 found "evidence of economically and statistically significant cost reductions at acquired hospitals," with average cost savings of between 4% and 7% in the years following the transaction.²⁵

- **Reduced capital expenditures.** Integration of a smaller hospital or health system into a larger health system can help the larger system avoid the high costs associated with construction of a

new facility. Santa Clara Valley Medical Center, which was running near capacity before integrating St. Louise Regional Hospital and O'Connor Hospital into its system, was able to avoid the costs of adding additional capacity through construction. The fact that St. Louise and O'Connor have both seen non-COVID-19-related inpatient volume growth at a time when many facilities faced declines in non-COVID-19 volumes is evidence of the capacity demand that was sorely needed within the region. In cases where a new facility is required, a joint venture integration strategy similar to Providence and Cedars-Sinai's partnership on Tarzana Medical Center can share the costs of new construction between systems, lessening the capital burden on each.

- ***Reduction or elimination of redundant or duplicative services.***

Integration can provide resources for smaller hospitals to acquire or upgrade an EHR system and integrate that system with both affiliated physicians and the larger health system. Larger systems can also deploy their research on care protocols to smaller hospitals that they partner with, helping eliminate redundant or medically unnecessary testing and procedures.

CommonSpirit is among the top Medicaid providers in the country, with a special emphasis on serving high-risk communities and patient populations. With Medicaid payments covering, on average,

“We saw the creation of a new system as an opportunity to realize our fundamental belief that everyone has the right to be healthy. We believe we are the largest Medicaid provider in the nation, and the ability to scale our strengths—evidence-based practices, clinical expertise, technological resources—across the health system footprint means that we can bring much-needed, quality healthcare to people who might not otherwise have access to this level of service.”

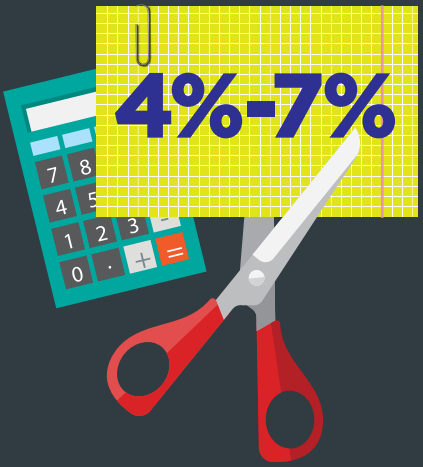
CHARLIE FRANCIS, SENIOR EXECUTIVE VICE PRESIDENT,
CHIEF STRATEGY AND TRANSFORMATION OFFICER,
COMMONSPIRIT

just 90 cents of every dollar spent on care, according to American Hospital Association statistics, CommonSpirit's mission-driven focus on providing care to those most in need requires a commensurate focus on cost efficiency. When the health system was formed in 2019, it set a goal to reduce costs by some \$2 billion and is more than halfway to that target. Similarly, St. Francis Medical Center in south central Los Angeles has been able to eliminate, on average, two days from patients' lengths of stay since it was purchased out

of bankruptcy by Prime Healthcare in August 2020, reducing costs and improving the patient experience.

Total cost of care is a more appropriate focus than unit price. Academic medical centers, for example, have a reputation as being high-price sites of care. They also have been highly active in integration activities: a 2017 article noted that while major teaching hospitals make up less than 7% of non-federal hospitals in the U.S., they were involved in 20% or more of change-of-control integration transactions in the prior three years.²⁶ Yet the quality of care academic medical centers deliver and the leading-edge care protocols they develop can make the total cost of care less than at other hospitals.

A study of costs of care for Medicare beneficiaries led by researchers at Harvard's T.H. Chan School of Public Health found that although initial costs were higher at major teaching hospitals (due in part to high outlier payments for the sickest patients), overall spending was lower at major teaching hospitals 30 days into the episode of care than at non-teaching hospitals, a result the researchers attributed to lower spending on readmissions and



A study of transactions from 2000 – 2010 found average cost savings between 4% and 7% at acquired hospitals in the years following the transaction.

MATT SCHMITT,
“DO HOSPITAL MERGERS
REDUCE COSTS?”

post-acute care for the major teaching hospital patients.²⁷ A higher initial price for higher quality care, in other words, can be offset by a lower total cost of care overall. As several interviewees for this report noted, the ability of academic medical centers to share their care protocols and high-quality outcomes more widely through integration provides a significant benefit to patients.

5 The COVID-19 pandemic has demonstrated that integrated health systems are indispensable.

The COVID-19 pandemic has made clear that integrated health systems are vital resources when responding to a public health crisis. Interviewees from integrated systems cited the ability to seamlessly shift resources (both staff and supplies) to harder hit facilities and to designate COVID-19 and non-COVID-19 facilities to segregate infected patient populations from other patients as key advantages they had over independent hospitals in confronting the pandemic. Hospitals that had integrated with academic medical centers also cited their ability to participate in treatment and vaccine trials and to have access to the latest care protocols in treating hospitalized COVID-19 patients as real benefits to the health of the patients and communities they serve.

Although research on integration and the response to COVID-19 is still in the formative stage, early indications are that integration offered several benefits with respect to patient care. In particular, an October 2020 article published in *Health Affairs* noted the survival benefits of regionalization, where acutely ill COVID-19 patients could be transferred to well-equipped hospitals that had high annual volumes of patients requiring mechanical intervention. But where referring and admitting hospitals were

“When it comes to the COVID-19 pandemic, there’s no doubt in my mind that if Prime was not here, the surge would have crushed this hospital. Prime Healthcare has been a tremendous buoy for the hospital and for the south central Los Angeles community because of its ability to be flexible in responding to changing conditions. We were able to pivot quickly—from securing massive amounts of PPE for staff and patients, to getting a federal DMAT team, to expanding ICU capacity, flexing beds, and even standing up care tents in our parking lot.”

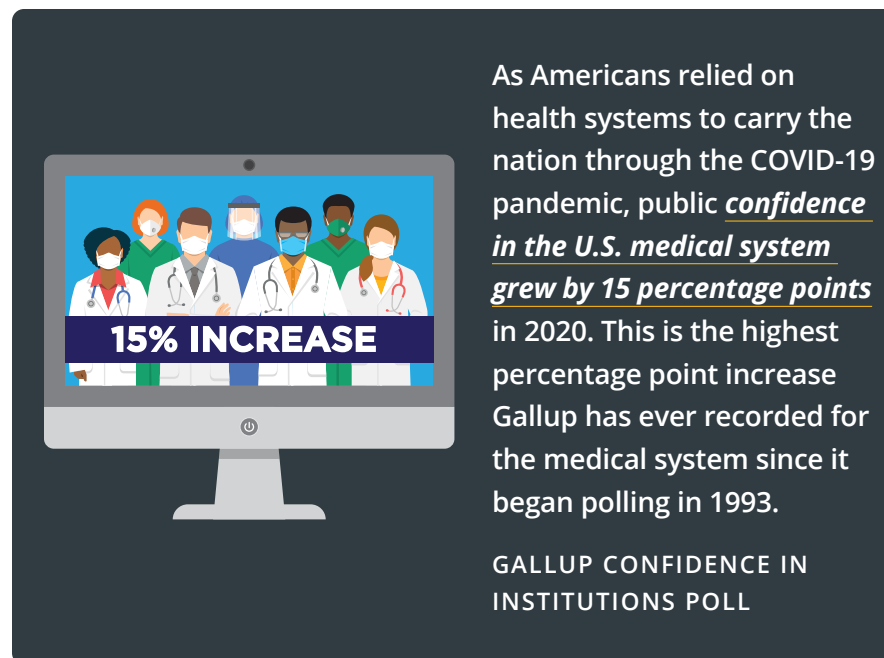
DAN JONES, CPPS, FACHE, CEO,
ST. FRANCIS MEDICAL CENTER

not integrated, the familiar barriers of a fragmented health system interfered with patient care. Referring hospitals and physicians, for example, feared the loss of revenue and autonomy when patients were referred.²⁸

Another study by researchers at the University of California, San Francisco, found that while there was a relationship between the number of COVID-19 mortalities and a higher burden of COVID-19 patients, that relationship was not significant at larger hospitals with more than 20 COVID-19 admissions, suggesting “that larger hospitals may be more resilient in the face of patient surges.”²¹ Additional research is needed, but these findings suggest that integrated systems that can more easily redeploy clinical staff, that have more experience dealing with high volumes of patient cases, and that can more easily ease the burden of cases by coordinating patient care across multiple facilities are better positioned to address public health emergencies such as COVID-19.²⁹

Finally, another *Health Affairs* article noted that the greater scale and resources of integrated health systems were:

...a major societal benefit in coping with COVID. Over this period, health systems have demonstrated that they are a vital part of our public health infrastructure. While the public benefits of health systems are difficult to quantify, they have performed far better than just about any other element of our society in responding to COVID.³⁰



Conclusion

Many California hospitals would have been unable to survive the challenges of a rapidly changing healthcare environment without integration. These challenges have only intensified, and integration will remain a vital tool for hospitals and health systems within the state as they continue to transform themselves to meet the needs of their patients and the communities they serve.

Integration has already achieved many benefits for Californians. It has:

- Made integrated health systems viable and attractive partners for health plans seeking to collaborate on offerings that increase the accessibility and affordability of care for consumers
- Stabilized financially struggling hospitals, expanded the services they offer to their communities, and increased the resources available to enhance the patient experience of care
- Facilitated innovations in care delivery and payment models to improve the quality and affordability of care

- Enabled efficiencies and information sharing that can reduce the total cost of care
- Positioned integrated health systems to respond to public health emergencies and lead the state's response to the COVID-19 pandemic

The authors of the *Health Affairs* article, cited in the preceding section, that described the major societal benefits integrated health systems provided in dealing with COVID-19 had important words for policymakers as well. "It is time," the authors concluded, "for the policy community to reconsider what has been, in the past two decades, an increasingly hostile posture toward these large complex enterprises and consider what steps can be taken to encourage them to take a broader public health role."

Endnotes

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- ³ This discussion defines the most highly integrated states as those in which 80% or more of community hospitals are in a system, including the District of Columbia, Florida, Hawaii, North Carolina, Rhode Island, South Carolina, Tennessee, Utah, and Virginia. The least integrated states are those in which fewer than 40% of community hospitals are in a system, including Alaska, Kansas, Montana, Nebraska, Vermont, and Wyoming.
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- ¹⁴ *Federal Trade Commission v. Thomas Jefferson University*, U.S. District Court for the Eastern District of Pennsylvania, Dec. 8, 2020.
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Qualifications, Assumptions and Limiting Conditions (v.12.08.06):

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