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Band-Aid Station or Tertiary Center? The Impact of Consolidation on Community Hospital Services

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In recent years, we have seen an increase in financially strong hospitals seeking larger partners. This has been driven by a variety of factors, including network pressure from growing managed Medicare and Medicaid plans, a desire for operating stability post-COVID-19 disruptions, narrow-network development in select markets, and others. One of the most common concerns we hear from board members of financially strong community hospitals considering transactions is that they will lose local control over what services to provide for their communities. More often than not, a board member will express concern that their facility will be turned into a low-acuity "Band-Aid station" as the larger system guts services to feed its tertiary hub. On the other end of the acuity spectrum, rural hospitals worry that a system partner will not have the same commitment to obstetrics services, leaving residents to drive miles for deliveries.

To address these concerns around care delivery, we considered client experiences as well as statistical analyses reviewing case mix and service access that Juniper has conducted over the years. This article summarizes those findings and considers why systems can be at an advantage to standalone hospitals at increasing local access to care.

Case Mix Index

Case mix index (CMI) reflects the severity, clinical complexity, and resource needs of all the patients in the hospital and offers a single number to compare facilities. The more

challenging the procedure, the higher the CMI. In other words, hospitals with very high CMIs are performing transplants and neurosurgery and hospitals with low CMIs are caring for a disproportionate number of patients with pneumonia. Offering exceptional care for illnesses like pneumonia is core to the missions of most community hospitals and hub facilities are often the most-appropriate sites to seek treatment for complex conditions, but on a continuum, CMI is a good indicator of whether residents will be able to access a full range of care at their local hospital or will need to travel outside their communities.

In 2020, we used multiple linear regression analyses to compare CMI at system hospitals and standalone facilities with similar numbers of ICU beds, payer mix, hospital compare scores, patient days, and average length of stay. That research found that community hospitals that are members of systems have higher CMIs than similar independent facilities. While that statistical analysis is more robust than client examples, we have found examples bring the data to life. The table below shows the experience of five Juniper clients that joined larger systems in the mid-2010s. It compares their Medicare CMIs in 2017, shortly after joining their partners and then again five years later once they had integrated into those systems. On average, Medicare CMI went up by over 10 percent after these community hospital organizations joined their larger partners.

Partnership Year	Hospital	Partner	Medicare CMI	
			FY 2017	FY 2022
2014	Port Huron Hospital	McLaren Health Care	1.51	1.69
2015	KishHealth	Northwestern Medicine	1.58	1.70
2015	Aria Health	Jefferson Health	1.66	1.81
2015	Lodi Memorial Hospital	Adventist Health	1.43	1.58
2016	Ingalls Memorial Hospital	UChicago Medicine	1.56	1.77

Access to Obstetrics

As a result of tightening operating margins across the industry, hospitals often face difficult decisions to keep the doors open. One option to reduce losses is to eliminate services with typically low profit margins, like obstetrics. This has created an obstetrics crisis in rural communities with only about 40 percent of rural hospitals offering obstetrics. Closures of obstetrics units in rural facilities can mean mothers driving hours instead of minutes, which contributes to the United States trailing the rest of the industrialized world in infant and maternal mortality.

U.S. Acute Care Hospitals			
	Independent	**In System**	**Total**
Rural Hospitals[1]	791	1,051	1,842
Rural Hospitals[1] w/ Obstetrics	305	476	781
% of Rural Hospitals[1] w/ Obstetrics	**38.6%**	**45.3%**	**42.4%**
Non-Rural Hospitals[2]	419	2,884	3,303
Non-Rural Hospitals[2] w/ Obstetrics	227	1,685	1,912
% of Non-Rural Hospitals[2] w/ Obstetrics	**54.2%**	**58.4%**	**57.9%**

1. Rural acute care hospitals are defined here as critical access hospitals and short-term acute care hospitals with sole community provider status.
2. Non-rural acute care hospitals are defined here as short-term acute care hospitals without sole community provider status.

This trend is especially prevalent in standalone rural hospitals, which are 17 percent less likely to offer obstetrics services than rural hospitals that belong to systems. While system affiliations alone are not enough to solve the crisis in access to maternal care in rural communities, they offer significant hope. Further, this stark difference in care delivery makes the cost of independence clear.

Why Do Systems Offer Better Access to Care?

This research indicates that systems can be an advantage when it comes to providing access to both complex care, as measured by CMI, and to lower-acuity services, as demonstrated by obstetrics offerings. However, for many standalone hospitals and concerned board members, this remains counterintuitive. We believe that part of the discrepancy in popular sentiment vs. outcomes relates to consolidation in other industries. For example, it is common in health insurance mergers to see payrolls slashed and service lines paired to wring out unit efficiencies and return ever-greater profits to shareholders. Not-for-profit hospital systems do not have shareholders and reinvest their earnings back into their missions. Increasingly, efficient health systems have a narrow set of outlets to redeploy capital. These include investments such as further expansion, facility improvements, spending more on employees (including increased nurse staffing ratios), technology improvements, and, as our research clearly demonstrates, providing increased service access for the communities they serve.

These findings challenge the well-funded narrative currently being promulgated by deep-pocketed, national, for-profit payers. Those organizations have used their scale to squeeze hospital providers, extracting huge profits that are then distributed to shareholders. While payers continue to consolidate, they have been successful in creating a narrative that

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not-for-profit hospital system growth is a greater threat to healthcare consumers than insurance company shareholder distributions. The top five insurance companies control 50 percent of the U.S. health insurance market, while the top five health systems do not break 15 percent national market share. But market power, as measured by share, is not the issue. It is the fact that insurance companies use that power to underpay health systems and then distribute those savings to their owners. Not-for-profit health systems that are able to nudge this balance back towards equilibrium do not extract profits to enrich shareholders, but instead reinvest those efficiencies back into our healthcare system. As our research shows, health systems are using some of their scale efficiencies to offer better access to care for their communities than standalone facilities.

Board Discussion Questions

- What is the board's role in making service and access decisions?
- How can our hospital ensure local access to low-acuity services, like obstetrics, as well as complex services?
- What are the clinical implications of maintaining our standalone status?

Conclusion

Like their standalone peers, systems are mission driven and committed to caring for the communities they serve. However, system hospitals are able to realize scale efficiencies that result in more resources to provide that care. Their higher margins aren't the result of providing less care, instead their higher margins allow them to provide more care closer to the communities they serve. A higher CMI observed in system hospitals signals that these hospitals perform higher-acuity, more complex procedures. Not only do system hospitals have higher CMIs, but they have additional capital to reinvest in patient care, greater ability to focus on their community-specific missions, and to reduce outmigration, just to name a few. While there has recently been pushback on system formation from regulatory agencies, this desire to keep hospitals local and subordinate to national payers comes at a significant cost to patient care and access.

TGI thanks Jordan Shields, Partner, and Duncan Cannon, Analyst, Juniper Advisory, for contributing this article. *They can be reached at jshields@juniperadvisory.com and dcannon@juniperadvisory.com.*