ORIGINAL ARTICLE

Academic Medical Centers and Community Hospitals Integration: Trends and Strategies

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Abstract

Academic medical centers are widely recognized as vital components of the American health care system, generally differentiated from their community hospital peers by their tripartite mission of clinical care, education, and research. Community hospitals fill a critical and complementary role, serving as the primary sites for health care in most communities. Health care reform initiatives and economic pressures have created incentives for hospitals and health systems to integrate, resulting in a nationwide trend toward consolidation with academic medical centers leveraging their substantial assets to merge, acquire, or establish partnerships with their community peers. As these alliances accelerate, they have and will continue to affect the radiology groups providing services at these institutions. A deeper understanding of these new marketplace dynamics, changing relationships and potential strategies will help both academic and private practice radiologists adapt to this ongoing change.

Key Words: Academic medical centers, community hospitals, consolidation, mergers

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INTRODUCTION

Historically, academic medical centers (AMCs) have served critical roles in the US health care system. Along with providing clinical care, they encourage innovation, research, and product development; identify and validate emerging care pathways; and provide education and training for the next generation of providers. They also serve as safety net hospitals for at-risk populations. Community hospitals fill a critical and complementary role, accounting for approximately 80% of all hospital admissions each year and serving as the primary sites for health care in most communities [1].

Recent health care reform initiatives are incentivizing higher levels of care coordination and system integration. As hospitals and health systems embark down these new care pathways, mergers, acquisitions, and new partnerships are being aggressively pursued. Many new models focus on better alignment of general community and subspecialty academic facilities. Radiology practices already have and will continue to be disrupted by these changes.

DELIVERY SYSTEM CONSOLIDATION

In response to recent legislative, economic, and regulatory pressures, nearly all sectors of the health care industry are rapidly consolidating. Between 2009 and 2013, hospital merger and acquisition volume increased by 14% annually [2]. More than $143.3 billion in health care mergers and acquisitions took place in 2012. The percentage of system-affiliated community hospitals grew from 53.6% in 2003 to 63.2% in 2013 [1,2]. Approximately 36% of AMC hospital CEOs responding to a recent survey

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asking what best described their organization's approaches to funding and revenue challenges chose merger and acquisition activity. Only 13% are sustaining strategies to maintain institutional independence [3].

A subset of the health system delivery consolidation trend has been the development of partnerships or mergers between AMCs and community hospitals. As AMCs seek these new relationships, radiology departments become engaged almost by necessity to effectively meet the needs of the new parent enterprise. The expansion of AMC radiology departments into the community was discussed nearly a decade ago [4], but the broader health care delivery landscape has changed dramatically in the interval. Academic practices are rapidly adapting to provide services to the community settings, whereas smaller private groups often do not have the resources required to satisfy the subspecialty referrals. Despite legacy loyalties to established radiology practices, consolidation has forced at least some private groups to affiliate with, assimilate into, or be displaced by larger academic departments.

AMC mergers have not been uniform. The diversity of models is a direct result of regional political, financial, and/or microeconomic factors. Some institutions have chosen not to change their strategy. Others have had massive expansions well beyond their regional territories [5]. And in some cases, AMCs have considered mergers or partnerships with other AMCs [6]. On the flip side, AMCs have infrequently been the target of acquisitions themselves [7].

AMCs: WHAT MAKES THEM UNIQUE

An AMC traditionally includes a hospital, a medical school or substantial faculty and teaching enterprise, and research or laboratory facilities [5]. Although the number of teaching hospitals is much greater, just over 130 institutions across the nation are considered AMCs. As a result, their overall geographic footprints are limited. But because these institutions collectively graduate nearly 17,000 physicians each year and conduct the vast majority of basic, clinical, and health services research, their overall impact on the health care system more broadly is quite substantial [1].

AMCs have traditionally differentiated themselves from most community hospitals in their tripartite mission of clinical care, education, and research. The missions are closely interwoven within most AMC governance, management, and financial structures, resulting in highly complex matrixed organizations. Similarly, because most AMCs have established themselves as centers of education and innovation, many have historically been resolute not to dilute their well-established brands. AMCs also tend to care for higher complexity and riskier patients, serving as referral centers for many community hospitals and providing important safety net services.

AMC MARKETPLACE DRIVERS AND HEALTH CARE REFORM

AMCs have been disproportionately targeted by health care reform initiatives [6]. Recent projections indicate that up to 10% of AMCs' funding may be at risk in the near future, creating substantial challenges for AMCs given that operating margins currently average only 5% [1,5,7].

Clinical Revenue

Clinical care constitutes an average of 85% of available revenue for AMCs [1]. Currently, AMCs have greater percentages of patients in Medicare and Medicaid compared with most community hospitals [8]. Even though many AMCs will benefit from previously uninsured patients being covered by Medicaid as a result of the Patient Protection and Affordable Care Act, this increase in low-margin business will be offset by a relative decrease in high-margin commercially insured patients who have greater access to alternative hospital systems [1]. AMCs in states that have not expanded their Medicaid programs or are experiencing budgetary pressures to reduce health care spending will also experience a negative financial impact.

Costs of Care

AMC costs are 10% to 20% higher on a case-mix-adjusted basis as a result of added staffing costs, faculty compensation plans, and clinical program mix [5]. AMCs also provide a disproportionate share of care for the uninsured: although AMCs account for only 20% of all hospital admissions, they are estimated to provide at least 40% of all uncompensated care [1].

Higher costs for care at AMCs have traditionally been offset by premium pricing for privately insured patients, a practice referred to as price discrimination [8]. Yet recent health care trends (eg, consolidation of private insurers, improving price transparency, and increasing health care cost sharing by patients and employers) are placing substantial pressure on AMCs to become more competitive in their pricing, particularly in markets in