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Provider/Payor convergence: A prescription for growth?

The baby-boom generation is aging and the United States is lagging in health care efficiency and life expectancy. Now that the Affordable Care Act is being implemented, traditional models will no longer create growth, and payors and providers are looking for ways to create scale and competitive advantage. In their pursuit of continued high performance, some players are turning to convergence, or vertical integration.

This article summarizes "Provider/Payor Convergence: Regulatory, Governance and Operational Issues You Need to Consider," the second of two webcasts covering the ins and outs of convergence for health care providers and payors. Panelists from Johns Hopkins Institutions, Buchanan Ingersoll & Rooney PC, and Grant Thornton LLP share their experience and offer insight.

Convergence: A path to continued growth

In health care, the traditional growth model is obsolete. Reimbursement cuts, new regulations and heightened regulatory scrutiny, pricing increase limits, increasing consumer awareness, and new partnerships and brands have changed the way both payors and providers do business.

Consumers now have the ability and the power to drive more of the health care process, and payors and providers have not yet learned to effectively manage this changing reality. According to panelist Mark Lastner, Business Advisory Services director at Grant Thornton, "Understanding and reacting to shifts in consumer power and preferences will be key to competing in future markets."

In health care, the traditional growth model is no more

As bottom lines shrink, payors and providers are beginning to see convergence as a route to growth through efficiencies, the ability to innovate and create stable networks. If done right, this can lead to enhanced capital availability, better health population management and more infrastructure investment. On the other hand, an ineffective convergence strategy can lead to antitrust scrutiny, regulatory hurdles and heightened business risks. David Tyler, Grant Thornton Health Care Advisory Services principal, says, "It's time to thoughtfully consider convergence as a long-term growth strategy."

Payors may face more regulatory scrutiny

The payor side has traditionally been more heavily regulated and scrutinized by a wider range of governmental entities. In particular, each state has its own specific requirements and its own commissioner. A payor (or its subsidiaries) licensed in more than one state is regulated by each of those states, even if the primary regulator is identified by where the company is domiciled.

Adding provider operations to a payor's entity structure can create regulatory challenges.

Panelist Jack M. Stover of Buchanan Ingersoll & Rooney notes, "State regulators will be looking carefully at the financial aspects of transactions that result in economic impacts for payors/insurers arising from convergence transactions involving payor and provider interests." As a result, Stover feels that "as provider/payor converged structures become common, expect an evolving push by state regulators for more authority, along with a broader interpretation of existing authority."

Adding provider operations to a payor's structure can create regulatory challenges. For example, the combined entity transaction may well fall under state statutes regulating such areas as investments and investment practices, acquisition or change in control of insurance entities, transactions within a holding company system, financial performance and operations, market conduct and competition, product review and approval, licensing of producers who sell insurance products, and receipt and resolution of consumer complaints.

Ronald E. Chronister of Buchanan Ingersoll & Rooney sees enterprise risk as another emerging focus area for state regulators. "Enterprise risk may be heightened in convergence transactions because risks inherent in the provider organization may have the potential to adversely impact the insurer," he says. He also notes that enterprise risk now involves new requirements, including submission of an annual report coupled with an expansion of the examination authority under state holding company acts to include affiliates (to the extent that an affiliate may pose enterprise risk to the payor).

Both Stover and Chronister noted that state regulators will also examine convergence transactions between payors and providers with respect to competition and market conduct. In this regard, state regulators will look at contracting provisions including exclusive or most-favored nation provisions and provisions limiting consumer choice, and determine whether contract provisions are in the public interest or for the benefit of policyholders. Stover says, "Payors may also need to take actions like creating firewalls between entities to address competition and privacy concerns."

Chronister pointed to a renewed focus on corporate governance as a state regulatory concern in convergence transactions. He noted that some state insurance regulators are concerned about the extent to which an insurer's board of directors is actively engaged in meaningful oversight and discussed implications of a new model act currently being considered by the National Association of Insurance Commissioners that deals with governance.

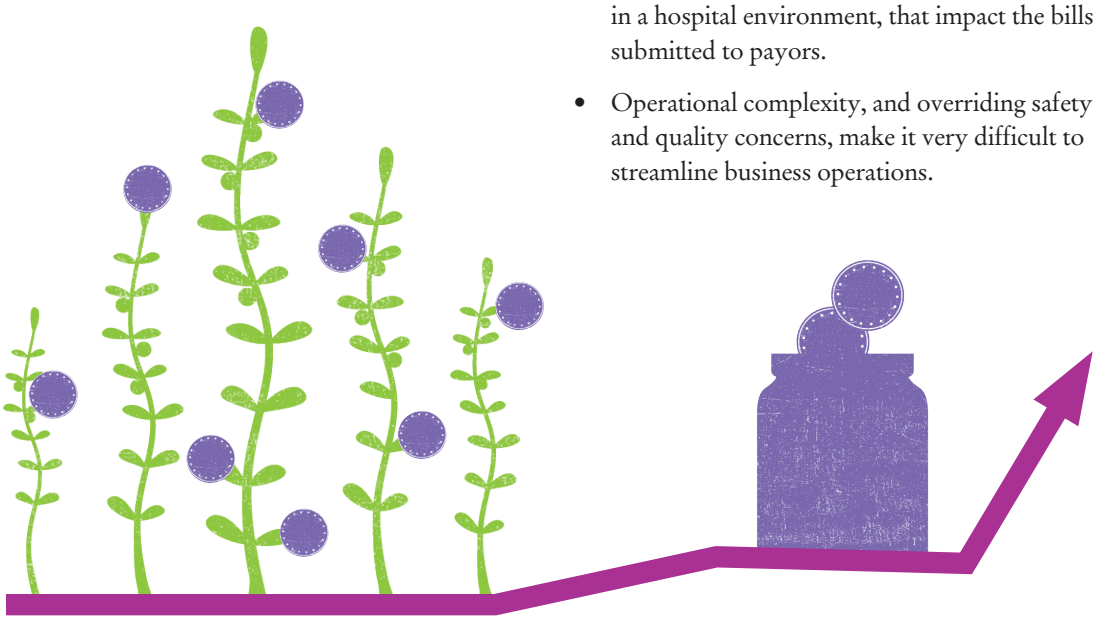
The changing landscape for providers

For providers, the economics are driving a push toward convergence. Traditionally, the fee-for-service business greatly helped hospitals and other providers, but the reimbursement market is changing rapidly due to capitation, quality and patient satisfaction-based rates, and incentives to reduce utilization. Providers have also made huge capital investments at a time when there are many threats to inpatient-based services.

Panelist Frank Bossle of the Johns Hopkins Institutions explained some of the challenges his organization has faced with their converged systems. "We have a 'health plan within a health system,' meaning we serve primarily as a Medicaid MCO (managed care organization) for the state of Maryland that includes over 300,000 insured lives," he says. "The challenges for the health plan lie in rationalizing the cost of care (within the converged entity versus out-of-network) and issues within the converged entity over minor things like billing and denials."

Bossle says that organizations contemplating convergence should prepare by looking at some important points:

- Payors seeking to get into the provider business will likely underestimate the complexity of providers.
- There are many steps and handoffs, especially in a hospital environment, that impact the bills submitted to payors.
- Operational complexity, and overriding safety and quality concerns, make it very difficult to streamline business operations.



What makes a successful convergence

Accountable care organizations (ACOs) bridge the gap that has traditionally existed between payors and providers. ACOs are generally created through a transaction, but creating a successfully combined entity through convergence is more complex.

The Centers for Medicare & Medicaid Services (CMS) has been tracking ACOs and recently released findings[1] on a number of its initiatives to reform the health care delivery system:

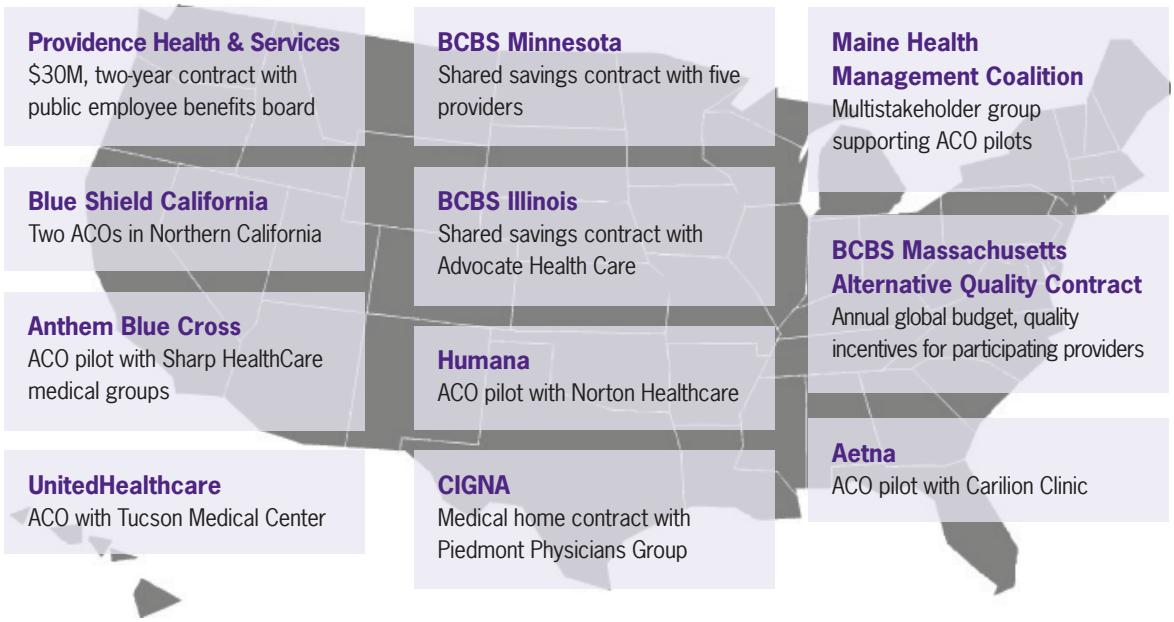
- Nearly half of the 2012 ACOs (54 out of 114) successfully reduced spending for attributed beneficiaries below their expenditure target — meaning more than half did not.
- 29 of the ACOs generated enough savings to qualify for shared savings bonuses (one in four — meaning 75% of ACOs did not).
- These top-performing ACOs earned $126 million in shared savings payments.
- Overall, the 2012 ACOs generated $128 million in net savings for CMS.
- Final year-one performance data for Medicare Shared Savings Program participants will be released later in 2014.

This news is encouraging yet cautionary and, as buyers and sellers continue to evaluate and execute these types of transactions, they should focus on strategic, operational, cultural, financial and people considerations.

Strategic

In evaluating strategic risks, it's important to understand the rationale for the transaction — it shouldn't be "me too," but rather a way to reduce costs, better serve consumers and strengthen your organization's financial future. It's also important to match the opportunity to the market by carefully looking at timing and potential partners. According to Grant Thornton's Tyler: "Realize that this is not a zero-sum game. Look at other payors, other providers and other reimbursement incentives."

Private payor ACOs emerging nationwide



[1] U.S. Department of Health and Human Services. "Medicare's Delivery System Reform Initiatives Achieve Significant Savings and Quality Improvements — Off to a Strong Start" (press release), Jan. 30, 2014. See http://www.hhs.gov/news/press/2014pres/01/20140130a.html for details.

Operational

With a transaction comes the need for new skill sets, expanded (or consolidated) IT, management processes and a host of new regulatory compliance requirements that must be met. The merged organization must also look at such processes as clinical capabilities versus actuarial capabilities and dual-sided analytics, where synergy opportunities exist — the trick is to focus on the real opportunities. The organization must define revenue centers versus cost centers, how to physically locate the organizations together, and where to invest and where to cut costs. These operational decisions can turn a smart deal into a not-so-smart deal if the wrong choices are made.

Financial

Integration takes financial resources to do it right. The organization must make efficient decisions that have a balanced impact on reserves. According to Tyler: "Financial system integration — EMR/ERP (electronic medical record/enterprise resource planning), claims platforms, business intelligence/analytics, and cost accounting — must all work together. It's a critical component to convergence success." Other important financial components for success include financial process integration (e.g., budgeting and planning), shared services, cash flow impact and reporting. "Not speaking a common financial language can easily lead to major issues down the road," Lastner warns.

"Your people are a major asset and a valuable one."

David Tyler, Principal, Heatlh Care Advisory Services
Grant Thornton LLP

Cultural

New roles and new colleagues mean a clear line of reporting and communication across the expanded organization is required. This can be a very difficult task. A long-term change management approach and the direct participation of the organization's leadership is needed to address such items as:

- Physician relationship management
- Medical management
- Negotiations with other entities
- Accountability for decisions on things like narrow networks and reimbursement premium levels

People

Intertwined with all the other risks are your people — without them, there can be major issues with business continuity. The corporate culture can break down. A training plan is important for learning new or changed skills. A retention strategy is important, too, along with aligning incentives. Grant Thornton's Tyler says: "This is not the time to slow down on things like coaching programs, performance evaluations and tracking management progression paths. Your people are a major asset and a valuable one, too — recruiting, hiring and training new employees is far more expensive than taking good care of the employees you already have."

Looking forward

Convergence is more than a trend — it's a moving train that you might be running alongside of, ready to jump aboard. It's a complex undertaking, and we encourage you to consider all that goes into a successful integration. Grant Thornton is ready to help.

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