

Recent Changes in Primary Care Delivery and Health Provider Systems in New Jersey

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Prepared by:

Allan Baumgarten, MA, JD

Allan Baumgarten, LLC



**Robert Wood Johnson
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SUMMARY

This project examined how, in recent years, New Jersey hospitals have formed larger systems through mergers and acquisitions, have entered into a variety of partnerships and affiliations, and have, along with other companies, opened convenient care clinics. Providers are responding to initiatives promoted by government (in the Affordable Care Act and elsewhere) and private payers that are slowly shifting health care away from fee-for-service payment and toward arrangements that place additional responsibility on providers for outcomes and managing the health of a designated population. Based on this analysis, the trend toward consolidation of providers is likely to continue and the importance of the strategic alliances is likely to grow. These trends are transforming New Jersey health care in important ways, including changing notions of how providers compete in local markets, introducing new provider organizations to the state, and blurring geographic boundaries and the lines that separated investor-owned and nonprofit health care organizations.

INTRODUCTION AND OVERVIEW

Like their counterparts in other states, New Jersey provider organizations are going through a period of transformation, dealing with major changes to payment arrangements and financial incentives, to approaches to care management and to the design of the private and public health benefit plans that cover the cost of care. Some of these changes were already underway prior to the enactment of the Affordable Care Act (ACA) in 2010. For example, many employers modified their group health benefit plans, shifting additional cost-sharing responsibilities to their employees in the form of high deductibles or co-payments. Similarly, their benefit plans often provided full coverage only when seeking care from a limited panel of physicians and hospitals. Non-emergency care received from providers outside that contracted network might not be covered or only covered after satisfying additional co-payments and deductibles.

In New Jersey and most other states, an increasing number of Medicaid recipients enrolled in plans in which managed care organizations guided their access to providers and care in exchange for a fixed per member monthly payment. Among health care providers, hospitals for decades have pursued a series of strategies to extend their reach geographically, to form larger organizations and to expand their patient base, sometimes through mergers and acquisitions and in other cases through strategic partnerships.

But clearly implementation of key elements of the ACA have given provider organizations a push along the transformation path and have also provided them with new tools or vehicles for making those changes. For example, provider organizations ranging from large hospital systems (Hackensack University and Meridian Health) to local physician networks (Partners in Care) in New Jersey have formed 17 Accountable Care Organizations (ACOs) through the Medicare Shared Savings Program (MSSP). In concept, ACO providers come together to improve care management for seniors not enrolled in Medicare Advantage plans. If they meet quality benchmarks and provide care for less than was spent previously for those seniors, Medicare shares the savings with the ACO entity and its participating providers. Other ACA initiatives are pressing hospitals to reduce the number of inappropriate readmissions and hospital-acquired conditions, or face reductions in their Medicare payments. Provider organizations are responding to those changes in payment and financial incentives by increasing their use of data analytics to identify high-utilizing patients. Furthermore, they are developing and implementing new measures to improve coordination of care for those patients, including better discharge planning and post-discharge follow-up.

The result of these changes is that most hospitals and physicians are beginning to see a greater, though slowly growing, portion of their revenues tied to outcomes in caring for a population. Less is paid based simply on the number of lab tests or procedures performed or on the number of hospital beds that are occupied each day. Part of the response of provider organizations and entrepreneurs is to develop urgent care and retail clinics, sometimes described as “convenient care” or “walk-in care,” in carefully targeted areas, so as to provide easily accessible alternatives to seeking care in hospital emergency departments. When appointments with primary care doctors are not available, these clinics provide daytime, evening and weekend access to a limited menu of health care services.

This research examined the strategies of provider organizations in New Jersey as they prepare themselves for the significant changes in primary care delivery that are now in progress and expected to unfold going forward. This paper is the first to use data from the research, and presents an analysis of the provider organizations in New Jersey and the strategies that they are pursuing.

The data used in this report is also available. The hospital and urgent care data sets can be found on the report page on www.rwjf.org. The exhibits mentioned throughout the report can also be found on the report page.

APPROACH TO RESEARCH

This report and the related data sets are based on three kinds of research. First, interviews were conducted with more than two dozen leaders in various health care organizations, including New Jersey state agencies, provider systems, networks and associations, health insurers, research centers, consultants, and community organizations. Most of the interviews were conducted “on background” and the interviewees are not quoted in this report. Their assistance and insights are much appreciated. Second, the data files for 2012 and 2013 operations from the annual Department of Health hospital survey were used to analyze hospitals and hospital systems on financial performance, inpatient utilization, and market share.¹ Third, searches of Internet web sites, business news media reports, and health care trade publications were used to prepare a chronology of hospital mergers and acquisitions in recent years and to develop an inventory of urgent care and retail clinics in the state.

PROVIDER STRATEGIES

As noted earlier, provider systems in the United States have been pursuing consolidation and growth strategies for much of the last two or three decades. At the beginning of this process, community hospitals in New Jersey joined together to form loose networks (maintaining separate governance and ownership) or more integrated systems, with combined governance, administration, and system-wide branding. The Barnabas system, for example, was formed in 1996 as an integrated network of eight acute care hospitals, most under separate ownership. Over the years Barnabas Health acquired several of the hospitals to form a more tightly organized system, while some of the original group of hospitals dropped out and formed other affiliations.

Why Expand?

National research by PriceWaterhouseCoopers shows that the pace of hospital deals continues to be

¹ Note that this hospital data file does not identify the state or zip code of residence of patients. Further, New Jersey residents, as will be discussed below, will travel to medical providers in nearby states, and residents of other states may travel to New Jersey hospitals and clinics. A separate data file is available that does provide patient residence information, allowing an additional analysis of where patients in New Jersey health facilities come from. And similar data files for nearby states would provide information about New Jersey residents seeking care in those states. To the extent that those data files showed that providers in nearby states saw large numbers of New Jersey patients, that outmigration would affect the market share and competition discussion that follows. That analysis was beyond the scope of this research.

vigorous, even though the total number of deals slowed from 94 deals in 2012 to 79 in 2014.² What accounts for this high level of merger and acquisition activity? Here are five reasons: First, provider organizations seek to increase their patient numbers and expand their geographic service area, particularly by adding new facilities in communities where the economy and population are growing, and then to establish a corporate brand across that area. Second, they seek to gain leverage in negotiating with private payers; this was the primary motivation for early rounds of hospital system building in the 1990s. Third, they are under pressure to achieve economies of scale for administration, and in particular, for investment in health information technology. Fourth, recent developments in national health policy has pushed them to establish fully integrated health care systems capable of managing the health of a large population and assuming insurance risk for their patients; this is the reason most frequently cited today.

One additional reason for hospitals to explore expansion strategies is that the market for inpatient care is shrinking in New Jersey and many parts of the country. In New Jersey, the number of inpatient admissions dropped 3.1% from 1.117 million in 2012 to 1.084 million in 2013, a loss of 33,300 inpatient admissions. In effect, hospitals in these states are competing for slices of a shrinking pie, and may feel that forming larger organizations could create a whole greater than the sum of its parts.

Hospital systems are formed and grow in several different ways. Hospitals acquire or merge with other hospitals or systems, which has been the most prominent vehicle for expansion. Second, they build new inpatient or ambulatory facilities, often in areas outside of their historic service regions. Some hospital system expansion occurs in a third way, through what is called vertical integration, namely, adding services and facilities like skilled nursing and rehabilitation, home health, and therapies. A fourth method for growing has accelerated in recent years, and that is acquiring or hiring physicians and their clinics to expand their patient base and generate hospital admissions and referrals to specialists. The fifth, which will be discussed at length in this paper, is by forming a range of strategic partnerships with other provider organizations. Finally, a provider system expands by entering the insurance business, either by acquiring or building its own health insurance company or HMO, or by partnering with an existing insurer to jointly market specific products, like a Medicare Advantage plan, or to accept significant financial risk for an identified population.

Like hospitals, physicians feel similar pressures to become part of larger organizations. Based on

² PriceWaterhouseCoopers, "Analysis and trends in US health services activity 2014 and 2015 outlook." Accessed at http://www.pwc.com/en_US/us/healthcare/publications/assets/pwc-health-services-deals-insights-2014.pdf

discussions with leaders in state medical associations and licensing boards, it appears that physicians in New Jersey are primarily practicing in small groups. But it is difficult for those small practices to make the necessary investments in health information technology and meet standards of meaningful use. Therefore, a growing number have entered into or are looking for arrangements where they gain the infrastructure to manage their practice and participate in population health initiatives. Some turn to employment relationships with hospital systems, while others turn to independent practice associations and practice management companies like Continuum, described below.

While implementation of the ACA really hasn't changed the list of reasons why provider organizations seek to expand, it may have changed the relative importance of those reasons. In all of the interviews conducted for this research with leaders in provider organizations and associations, an increasing emphasis on population health was identified as one of the most important reasons for provider systems to pursue growth strategies. Recent announcements of proposed mergers and acquisition often project that the proposed merger will help the combined organization achieve the Triple Aim of health care, as described by the Institute for Healthcare Improvement: (1) improving the patient experience (including quality and satisfaction), (2) improving the health of populations; and (3) reducing the per capita cost.³

The ACA has given provider organizations new incentives to consolidate, through a series of initiatives intended to redirect the American health system. For example, a small but growing portion of Medicare payments to hospitals is now tied to a series of performance measures. The goal is to move away from paying for each unit of service provided and instead reward providers for effectively and efficiently managing the health of a population. In January 2015, Health and Human Services Secretary Burwell announced a goal of basing 50 percent of Medicare payments on the quality of care provided, not on volume.⁴ Private payers like UnitedHealthcare have announced similar plans to increase the proportion of payments to providers tied to quality and health outcomes.⁵

With both government and private payers seeking to link performance and payment, what impact has that had on providers? General acute care hospitals in New Jersey and other states are now subject to a series

³ Taken from the Institute for Healthcare Improvement's web site, <http://www.ihl.org/Engage/Initiatives/TripleAim/pages/default.aspx> Accessed March 2015.

⁴ Department of Health and Human Services press release, January 26, 2015. Access March 2015 at <http://www.hhs.gov/news/press/2015pres/01/20150126a.html>

⁵ Bruce Japsen, "UnitedHealthcare's \$43 Billion Exit From Fee-for-Service Medicine." Posted at Forbes.com on January 23, 2015. Accessed March 2015 at: <http://www.forbes.com/sites/brucejapsen/2015/01/23/unitedhealths-43-billion-exit-from-fee-for-service-medicine/>

of possible bonuses and penalties tied to their performance with Medicare patients. *Exhibit 1* summarizes information for New Jersey hospitals on three Medicare bonus/penalty programs. The hospitals are grouped by system affiliation at the beginning of 2015 and in three groups of counties: Central, Northern, and Southern. The three programs are: (1) the penalty for excessive readmissions within 30 days for certain conditions such as heart attack and pneumonia, which can be as much as 3 percent in 2015; (2) the 1.0 percent penalty for hospital acquired conditions, in which the hospital's score exceeds 7.0 and (3) the value based purchasing bonus or penalty of up to 2.0 percent in 2015, based on a set of process measures and a second set of patient experience measures.

Exhibit 1 shows the excessive readmission penalties for 2014 and 2015, the hospital acquired condition score and the 1 percent penalty, if imposed, the bonus or penalty for value based purchasing, and the net of the bonus or penalties for 2015.⁶For 2015, 16 of 63 New Jersey hospitals earned value based performance bonuses, with the two hospitals earning the highest percentage bonuses being Deborah Heart and Lung Center in Browns Mills (0.74%) and Hackensack Mountainside in Montclair (0.49%). However, after the penalties for excessive readmissions and hospital-acquired conditions were subtracted from the bonuses, only three of the 16 netted additional payments.

All New Jersey acute care hospitals will be penalized in 2015 based on their readmissions, although six face a penalty of 0.1 percent or less.⁷The average penalty for New Jersey hospitals in 2015 is 0.82 percent, the 7th highest among the states. In four other eastern states, Connecticut, Delaware, New York, and Massachusetts, between 80 and 88 percent of hospitals will be penalized for too many readmissions. While most New Jersey hospitals face small penalties, two will see their Medicare payments reduced by more than 2.0 percent, and 19 others will see their Medicare payments reduced between 1.0 and 2.0 percent. In addition 23 New Jersey hospitals will suffer the 1.0 percent penalty for hospital acquired conditions.

In percentage terms, the amounts may seem small, but it is clear that the new penalties and bonuses are causing hospitals to re-examine their care management systems to ensure that more attention is paid to discharge planning and follow-up. Or that they are making certain capital decisions, such as converting all patient units to private rooms, or trying to find a better alternative to the hated hospital gown, in order to

⁶ Note that some hospitals report separately to the New Jersey Department of Health but report on a consolidated basis to Medicare. For example, the two AtlantiCare hospitals in Atlantic City report to Medicare as a single hospital.

⁷ Pediatric, critical access or certain specialty hospitals are not evaluated and are not subject to the penalty.

improve their patient satisfaction scores.

Mergers and Acquisitions

The most prominent strategy for provider system growth is mergers with and acquisitions of other hospitals or systems. In the past two years, more than 20 individual hospital acquisitions have been announced in New Jersey, not including the two large nonprofit system-to-system deals that are reported to be in the works. *Exhibit 2* lists the completed hospital acquisitions in the state and those still under state review in the past five years. These deals are not one size fits all; purchasers are local and national hospital companies, nonprofit and investor-owned. Some of the hospitals to be acquired or that will merge were in financial distress, while others are strong financially.

It is important to note that the process to gain approval in New Jersey for a change in hospital ownership usually takes more than a year, coming after a 6- to 12-month period in which the hospitals conduct their due diligence and negotiate key terms of the deal, such as who will serve in key executive or board positions and which electronic medical record system will be used by the combined organization. These changes in ownership usually are subject to a fairly stringent review required by New Jersey's Community Health Assets Protection Act (CHAPA).⁸ Under CHAPA and other statutes, Department of Health staff conducts a Certificate of Need review, and the proposal needs approval from the Department, the Attorney General, and a state court. Opportunities must be offered for community participation in the review process. If any terms or conditions are attached to the approval, the Attorney General and other state offices (and sometimes contracted organizations, such as universities) oversee compliance with those conditions. Proposals to close a hospital are also subject to various reviews.

Some of the acquisitions listed were announced first in 2013 and others in early 2014, but are still not complete. For example, the Geisinger Health System in Danville, PA is acquiring the two AtlantiCare Regional Medical Center hospitals in Atlantic City. That sale was announced in May 2014, but has not been completed. Barnabas Health announced a definitive agreement to acquire Jersey City Medical Center in May 2013, and that deal closed in June 2014. Atlantic Health in Morristown has completed the acquisition of Chilton Memorial Hospital in Morris County and in May 2015 received state approvals to acquire Hackettstown Regional Medical Center in Warren County. In the same week, the state commissioner of health approved the bid of Prime Healthcare of California to acquire the St. Clare's

⁸ N.J. Stat. Ann. §26:2H-7.11.

Health System hospitals.⁹

Investor-owned hospital companies are playing an increasingly important role in the state. Prime Healthcare, a California company that owns more than 20 hospitals in several different states, has been especially active in pursuing hospital acquisitions in New Jersey. It completed the acquisition of St. Mary's Hospital in Passaic in August 2014, 19 months after signing a purchase agreement. It is in the process of acquiring the Saint Clare's hospitals in Morris and Sussex Counties and St. Michael's Medical Center in Newark, a purchase that has been especially controversial.

The New Jersey Health Care Facilities Financing Authority, the state agency that guaranteed \$233 million in debt when St. Michael's was taken over by Catholic Health East (now Trinity Health) commissioned a consultant report about the hospital environment in Newark. The report concluded that the Newark area has a significant surplus of hospital beds and recommended that St. Michael's and another hospital (East Orange, also in the process of being acquired by investors) should be closed as inpatient facilities. Instead, the consultants recommended, they should be converted to "state of the art" ambulatory care centers, with major investments in those new centers and the remaining inpatient hospitals in the city.¹⁰ The report also looked at the role of University Hospital, the primary teaching hospital for the Rutgers New Jersey Medical School.¹¹

Given the importance of hospitals to local economies and employment, many elected officials have rallied to support the sale of St. Michael's so that it would remain open as an inpatient facility. In its response to the consultant's report, the hospital emphasized that implementing the recommendation would reduce competition in the Newark area, leaving Barnabas Health as the dominant provider. Citing research on the economic impact of locally dominant providers gaining significant market power, it projected that

⁹ Jason Koestenblatt, "NJ Health Chief OKs Sale of St. Clare's, Hackettstown Hospitals," *Parsippany Patch*, May 7, 2015. Accessed May 2015 at: <http://patch.com/new-jersey/parsippany/nj-health-chief-oks-sale-st-clares-hackettstown-hospitals-0>

¹⁰ Navigant Consulting, "Greater Newark Healthcare Services Evaluation," report to New Jersey Health Care Facilities Financing Authority, March 2, 2015. Downloaded March 2015 from <http://www.njhcffa.com/njhcffa/what/pdfs/NJHCFFA%20Final%20Report.pdf>

¹¹ In 2012 the New Jersey Legislature passed a law realigning the state's medical and dental schools, transferring them to Rutgers University, where they form a new Division of Biomedical and Health Sciences. That change, which took effect in 2013, elevates the importance of Rutgers University in medical training and research. In a related development, Seton Hall University and Hackensack University Health Network announced in January 2015 that they would jointly form a new private four-year medical school, to be located at the former Hoffman La Roche campuses in Nutley and Clifton.

Barnabas could raise its prices free of competitive pressures, possibly costing insurers and employers millions of dollars in additional fees.¹²

If it can gain final approvals, Prime Health would own four general acute care hospitals in New Jersey.¹³ In 2012, a group of investors acquired three struggling (two went through bankruptcy) hospitals in Bayonne, Hoboken, and Jersey City. In May 2013, those hospitals were rebranded as CarePoint. Recently CarePoint launched its own Medicare Advantage PPO plan, which has grown to about 6,000 enrollees as of January 2015.

The CarePoint hospitals have pursued a strategy of going “out-of-network” with major health insurers in the state. When a patient enters the hospital through the emergency department, the CarePoint hospitals charge very high rates, well above what insurers would pay to an in-network hospital. How significant a problem these charges are is a matter of heated dispute. The health insurers say that this is price gouging that drives up the cost of health insurance and puts a burden on patients with high-deductible health plans. These hospitals (and certain specialty physicians) say that the rates paid by the insurers are inadequate, especially given the current trend to offer limited networks of providers who agree to work for less. Hospitals and their associations also point out that some of these acquisitions are necessary to rescue failing hospitals, which has been the case in several instances in New Jersey, and ensure that their communities continue to have nearby access to those services. They also point out that acquisition agreements often include commitments to make significant investments in new facilities and technology that those hospitals could not afford to make otherwise.¹⁴

Some recent acquisitions have blurred the lines separating community nonprofit hospitals and investor-owned hospitals. For example, a joint partnership of Hackensack Hospital Network and LHP Hospital

¹² Saint Michael’s Medical Center (Newark, NJ) press release: “Saint Michael’s Medical Center Releases Response to Navigant Study,” April 15, 2015. Accessed April 2015 at <http://www.smmcnj.org/about-us/news/2015/saint-michaels-medical-center-releases-response-to-navigant-stud/>

¹³ Prime Health will soon own two hospitals in Michigan, another state in which for-profit hospitals are increasingly prominent. Its proposed purchase of St. Joseph Mercy Hospital in Port Huron from Trinity Health, the current owner of St. Michael’s, is undergoing state review, and it also bought Garden City hospital, one of the few remaining independent hospitals in the Detroit area. Prime recently withdrew its offer to buy the six Daughters of Charity hospitals in northern California. Trinity Health, based in L’Avonia, MI, currently has 86 hospitals in 21 states, including four New Jersey hospitals in the Camden area, Trenton and Newark. Catholic Health East and Trinity merged in 2013, providing an example of a merger of national systems having an important impact at the local level.

¹⁴ For example, in announcing that it had completed its acquisition of St. Mary’s Hospital in Passaic, Prime Healthcare Service repeated its commitment to make \$30 million in capital improvement investments in the hospital. See the August 15, 2014 press release, accessed at: <http://www.primehealthcare.com/Press-Center/News/2014/Prime-Healthcare-Services-Acquires-St-Mary-s-Hos.aspx>

Group, based in Plano, TX, acquired two hospitals in northern New Jersey. Both deals were completed in July 2012. The partnership acquired Mountainside Hospital in Essex County and reopened Pascack Valley Hospital in Bergen County, which had closed in bankruptcy a few years earlier.

Four of the largest hospital systems in the state have announced that major deals were under discussion in the past year. In October 2014, Hackensack University Medical Center and Meridian Health announced their intention to merge, creating a system of nine hospitals and more than \$3.4 billion in annual revenues. Further, when the Meridian acquisition of the two Raritan Bay hospitals is completed, that gives the combined system an additional presence in Middlesex County, in addition to the Monmouth and Ocean County areas that Meridian now serves and the Bergen and Essex County service areas for Hackensack University. The combined system would be the largest in the state, leaping ahead of Barnabas Health.

The two systems already had close ties. Meridian and Hackensack were two of the seven New Jersey and Pennsylvania systems that had formed a loose network in 2013 called AllSpire Health Partners. (The others are Atlantic Health in New Jersey and Lancaster General Health, Lehigh Valley Health Network, Reading Health System, and WellSpan Health, all in Pennsylvania.) The two systems were also leading members of QualCare, a provider-owned network that rented access to a variety of payers, most recently the New Jersey operations of Health Republic and Oscar, two new health insurance companies selling to individuals in New York and New Jersey. QualCare formed a subsidiary to provide services to Medicare ACOs and that group has consulted to most of New Jersey's Medicare ACOs. Early in 2015, CIGNA announced that it would acquire QualCare, and that acquisition was completed in March 2015.

A few months later, Barnabas Health and Robert Wood Johnson Health announced that they were in discussions. In their releases and public comments, neither organization used the word "merger," instead saying that they were discussing collaborations and strategic partnerships. If the two did merge, it would create a system with about \$4.5 billion in revenues and 10 hospitals. And it would be larger than the proposed combination of Hackensack University and Meridian Health.

In interviews, some speculated that a future goal of these large systems is to form their own insurance companies, or as an intermediate step, assume insurance risk through a delegation arrangement with one or more major health insurers. Some of the large New Jersey systems are already engaged in partnerships with insurers to jointly market health insurance products for which the hospital system and its employed or affiliated physicians bear significant financial risk. These partnerships enable the hospital systems to

gain experience in managing insurance risk and understanding the kinds of care management and risk management tools that health insurers use.

For example, Meridian Health has partnered with Geisinger Health to offer a Medicare Advantage plan in Ocean and Monmouth Counties, which had grown to about 6,500 seniors in January 2015. (An interviewee commented that Meridian sought to expand its network to enter the market for commercial plans, but other provider systems did not want to help Meridian by joining its network.) The Hackensack system is jointly marketing commercial health plans with Aetna under a gain-sharing arrangement, described below.

Cooper University Medical Center began to venture into the health insurance business by establishing a self-funded health benefit plan for its employees, which now covers more than 9,000 lives. In April 2013, it acquired 20 percent of AmeriHealth New Jersey, an HMO and insurance company.¹⁵ During the open enrollment period that fall, they jointly offered individual plans in and outside of the Healthcare.Gov exchange. The product was built around the Cooper providers in a three-county area and was originally called Cooper Advantage. During the fall 2014 open enrollment period, Cooper Advantage was renamed Community Advantage as it expanded its service area and provider network into Atlantic and Cape May Counties.

With all of the completed and proposed mergers in New Jersey, the hospitals have touted the Triple Aim benefits of forming a larger organization, such as leveraging investments in health information technology, scaling up and replicating best practices, and bringing improved care management and high-quality specialists to a larger population of patients. On the other hand, employers and insurers are concerned that hospitals that gain significant market power use that increased leverage to raise prices. They cite research from the Federal Trade Commission (FTC) and others and point to papers offering options for addressing the problem of consolidation.¹⁶

¹⁵ AmeriHealth in New Jersey is part of AmeriHealth Caritas, which operates full-risk Medicaid plans in six states and is partly owned by Independent Blue Cross Blue Shield of Pennsylvania and Blue Cross Blue Shield of Michigan.

¹⁶ Jeff Goldsmith, Lawton R. Burns, Aditi Sen and Trevor Goldsmith, "Integrated Delivery Networks: In Search of Benefits and Market Effects," February 2015. Conducted for the National Academy of Social Insurance Panel on Addressing Pricing Power in Health Care Markets; Martin Gaynor and Robert Town, "The impact of hospital consolidation – update," June 2012, published by The Robert Wood Johnson Foundation Synthesis Project. Some options for addressing the problems of consolidation are suggested by Paul B. Ginsburg and L. Gregory Pawlson, *Health Affairs*, 33, no.6 (2014): 1067-1075. "Seeking Lower Prices Where Providers Are Consolidated: An Examination Of Market And Policy Strategies," published online on May 19, 2014, at 10.1377/hlthaff.2013.0810)

How concentrated is the New Jersey hospital market today and what would be the impact of completing all the proposed mergers that are in the pipeline now? The next group of exhibits examines market share and concentration for the major hospital systems based on net patient revenues and inpatient admissions. Using the 2013 hospital data set and based on the ownership that was in place then, *Exhibit 3* shows market share for hospital systems within each of the three regions. (Appendix A lists the counties and their regions.) Two measures are used: net patient revenues, which is defined as billed charges less discounts taken by Medicare and Medicaid or negotiated by private insurers, and inpatient admissions. For example, three systems in the central region – Barnabas, Meridian, and RWJ – have between 13.5 percent and 18.2 percent of the market measured by net patient revenues. Hospitals outside the systems account for 28.6 percent of the market.

In the northern region, where more large hospitals remain outside of the systems, independent hospitals accounted for about 40 percent of the market. None of the three large systems there – Barnabas, Atlantic Health, and Hackensack – had more than 15.9 percent of the market in 2013. In the southern region, only four hospitals remain outside of the large systems, accounting for 12.3 percent of net patient revenues. Virtua Health is the largest system, with 24.6 percent of the market, followed by Cooper University, AtlantiCare, and Inspira.

The next three exhibits rank the hospital systems by size at three points in time. *Exhibit 4* shows that Barnabas Health is the largest system in the state as of 2013, followed by Hackensack and Atlantic Health. These 11 systems account for 60 percent of net patient revenues and 63 percent of inpatient hospital admissions. In *Exhibit 5*, the same 2013 data are used to show system size based on ownership in March 2015. That reflects completed deals including the acquisition of Jersey City Medical Center by Barnabas and Atlantic Health's purchase of Chilton Hospital. The exhibit shows that the statewide market share of Barnabas Health grew from 10.8 percent to 12.5 percent, while the Robert Wood Johnson system grew from 5.9 percent to 6.8 percent, with the acquisition of Somerset Medical Center.

Exhibit 6 projects what the market share division would look like if all of the acquisitions currently under review by the state were actually completed, which is not assured. For example, if Prime Health's acquisitions of St. Michael's in Newark and Saint Clare's in Danville are completed, then it would have 5.8 percent of the regional market in northern New Jersey, based on 2013 net patient revenues. If

Geisinger Health completes its acquisition of the AtlantiCare hospitals, it would have 13.6 percent of the market in southern New Jersey.

If completed, the merger of the Hackensack and Meridian systems would create an organization with 26.3 percent of the market in the central region and 14.9 percent of the market in the northern region, where several large hospitals remain outside the systems. Further, if the discussions between Barnabas Health and Robert Wood Johnson did result in a merger of those two systems, the combined 2013 revenues would be 31.1 percent of the market in the central region, and 17.7 percent of the revenues in the northern region.

The geography of these potential mergers is very interesting and suggests that traditional definitions of local markets are blurring or perhaps becoming less relevant. In southern New Jersey, the largest systems – Virtua, Inspira, and Kennedy Memorial – have sought to extend their geographic reach, but largely within that region. As will be discussed in the next section, when planning sites for new urgent care clinics or health centers they seek to push out into neighboring communities, often in the backyard of their competitors.

The combination of Meridian and Hackensack creates a system that covers much of the northeast quadrant of the state. The facilities start in Bergen and Essex Counties in the north, skip over Newark and its suburbs for now, then to Middlesex County (with the Raritan Bay hospitals) and south along the shore to Monmouth and Ocean Counties. Barnabas Health was already in the Newark-Livingston-Jersey City area and at the shore with its two campuses in Long Branch and Lakewood.

Interviewees, including health plan leaders and community groups, were asked if they could point to specific instances where consolidated hospital systems had misused their market power. While they are familiar with the research cited above and believe that there is a risk that dominant local providers will misuse their market power to raise prices for employers and insurers, only one example was cited of possible misuse of market power: a major hospital that, after acquiring two community hospitals, is now charging the major hospital's higher rates for care provided at those community hospitals.

In interviews, the issue that is of most concern to employer purchasers and health insurers is the practice described earlier of hospitals and specialty physicians not contracting with health insurers and charging high out-of-network prices to them. In May 2015, a bill was introduced in the New Jersey Senate, Bill 20,

titled the “Out of Network Consumer Protection, Transparency, Cost Containment and Accountability Act.”¹⁷ Some analysts have suggested that the bill’s prospects for passage are strong.

Perhaps concentration here is not as significant as it is in other states, given that even within the three regions only one hospital system now has more than 20 percent of the local market. In the Toledo, OH, area, the ProMedica system has grown to become the largest system. In 2010, it acquired the St. Luke’s hospital and the FTC brought a complaint against ProMedica for antitrust violations. The FTC prevailed and it sought to require ProMedica to dissolve the acquisition. The Sixth Circuit Court of Appeals upheld the FTC and the U.S. Supreme Court refused to hear ProMedica’s appeal. In some other markets, the FTC has not challenged the emergence of locally dominant systems.¹⁸ If anything, there was more concern expressed about the strategy of for-profit hospitals that use their market power to go out-of-network with the health insurers and to charge higher prices.

Still, if large systems partner up, won’t others follow? If Atlantic Health completes its acquisition of Hackettstown Hospital and would join up with Hackensack-Meridian, the combined system would have a statewide market share of 23.6 percent, and 43.6 percent in northern New Jersey. That level of market share would likely get close scrutiny by antitrust regulators, though the definition of the relevant geographic market would be argued by the hospitals and the regulators. Hospitals would likely argue for a broad definition of geographic market, including not only most of the state of New Jersey but also providers and patient care in New York City and other areas. They would note that many New Jersey residents travel to New York and elsewhere to seek medical care. In other words, they would argue for a larger denominator of health care provision over which their combined share would appear less threatening.

As hospital systems promote the ability of larger systems to improve care quality, an underlying goal is to make the specialty care now available in some parts of New Jersey accessible to more New Jersey residents. In the process that could reduce the number of New Jersey residents traveling outside the state for care. A patient origin analysis that includes care provided to New Jersey residents in nearby states

¹⁷ The bill text, as introduced, can be found here: <http://www.njleg.state.nj.us/bills/BillView.asp?BillNumber=S20>. Horizon Blue Cross Blue Shield supports the bill and has posted a consultant analysis of the issues and the bill’s impact at: <http://www.WhatHealthCareCostsNJ.com>

¹⁸ The two major hospital systems in northeast Ohio, the Cleveland Clinic and University Hospital, combined have 81 percent of that market for hospital services in those counties. Those hospital systems continue to make acquisitions in other parts of the state. In the Detroit area, three hospital systems – William Beaumont, Oakwood, and Botsford – have merged, forming a system with about 30 percent of that local market, measured by patient revenues.

over a period of years might provide insight on whether the mergers and acquisitions did succeed in achieving those goals.

Affiliations and Partnerships

While key New Jersey provider systems are pursuing merger and acquisition strategies, they are also entering into a range of clinical affiliations and strategic partnerships. Many of these clinical affiliations are with academic medical centers and are centered on specialties like oncology and cardiovascular care. In part, these arrangements are part of a strategy to limit the number of New Jersey residents seeking specialty care (or even primary care) in Philadelphia or New York City. One approach is to promote the availability of providers with national brand names closer to home. Some examples: Virtua Health has an affiliation with Children's Hospital of Philadelphia (CHOP) where CHOP physicians practice at four Virtua locations in New Jersey. CHOP also has clinic locations in other parts of New Jersey, including four offices near Atlantic City. Both Virtua and CHOP promote the availability of CHOP providers in New Jersey. The marketing message is that New Jersey residents can get CHOP quality pediatric care at Virtua's facilities. Virtua, Hunterdon, and AtlantiCare are hospital partners in New Jersey for Fox Chase Cancer Center in Philadelphia.

Internationally known providers like Cleveland Clinic, Mayo Clinic, and M.D. Anderson Cancer Center in Houston also follow the strategy of developing local provider partnerships without acquiring them. Cleveland Clinic has established a network of affiliated cardiovascular hospitals around the United States, where local cardiologists follow Cleveland Clinic care protocols and can consult with experts at Cleveland Clinic. The newest hospital in that network is Valley Hospital in Ridgewood, NJ. In both cases (as well as the Mayo Clinic Care Network of partnerships), these national provider systems are usually partnering with smaller systems in local markets, not the largest ones.

In 2013, University of Texas M.D. Anderson Cancer Center entered into a partnership with Cooper University and established a comprehensive cancer center at the Cooper Health Science Campus in Camden. As part of a strategy of establishing regional outposts outside of Texas, M.D. Anderson had previously partnered with Orlando Health to establish an M.D. Anderson Cancer Center there. The oncologists follow M.D. Anderson protocols and also participate in clinical trials, another benefit to residents of the area. Again, the message is that New Jersey residents can get actual M.D. Anderson-quality oncology care close to home.

Mayo Clinic does not focus on a single specialty in its partnering with local hospitals. Local hospital partners that join the Mayo Clinic Care Network get access to telemedicine consults and other kinds of consulting, for example, how to reduce hospital readmissions. And they get to use the Mayo Clinic logo and brand in certain ways, again to send a message about high-quality care close to home. The program has grown to 30 local partners, but as of now there are no Mayo Clinic Care Network members in New Jersey and only one in the northeast.

The marketing value of these networks is important and becomes a point on which local hospitals compete. In Texas, the Methodist Hospital system in Dallas announced with much fanfare that it was joining the Mayo Clinic Care Network. A few months later, the BaylorScottandWhite system in Dallas and Temple announced that it was joining the Cleveland Clinic cardiovascular network.

On their web sites, several New Jersey hospitals tout their training and research ties to major academic medical center in and outside of that region. For examples, Monmouth Medical Centers in Long Branch, a Barnabas Health facility, has a longstanding relationship as a teaching hospital affiliated with Drexel University College of Medicine in Philadelphia. The Inspira Health Network entered into an affiliation with the Thomas Jefferson University and Health System in Philadelphia to connect clinical programs at Inspira with sub-specialists from Jefferson in cancer services, neurosciences, and gastroenterology. A new ambulatory care facility in Gloucester County, to be developed by Inspira and Jefferson, will include a cancer center that will be part of the Sidney Kimmel Cancer Center Network at Jefferson.

Five hospitals in southern New Jersey are part of the Penn Cancer Network: Cape Regional Medical Center, Monmouth Medical Center, Community Medical Center (Toms River), Kennedy Health, and Shore Medical Center. Hackensack University Health Network points to clinical and academic affiliations it has with medical centers like the NYU Langone Medical Center, Georgetown University School of Medicine and hospital, and Georgetown's Lombardi Comprehensive Cancer Center. Two Barnabas Health facilities, Saint Barnabas in Livingston and Newark Beth Israel, are teaching affiliates of Mount Sinai School of Medicine.

At the same time that New Jersey hospitals are trying promote getting care close to home, Philadelphia and New York provider organizations have expanded their presence in New Jersey. The goals are to offer convenient access to primary and specialty care in order to keep patients in their systems after they have relocated. Penn Medicine has developed medical centers in Cherry Hill, Marlton, Voorhees, and Woodbury Heights. It has affiliations with Shore Medical Center, and the Penn Maternal-Fetal Medicine

group has a practice as Shore Medical Center and at four other New Jersey locations. Other Penn Medicine departments, such as oncology, also have established clinical sites in New Jersey. Memorial Sloan Kettering Cancer Center of New York has established a diagnostic and treatment center in Basking Ridge, in Somerset County. In each case they seek to establish multiple points of presence in New Jersey to maintain and expand their patient base of New Jersey residents, who are also hearing from New Jersey providers about the availability of high-quality specialty care closer to home.

Accountable Care Organizations

The ACA created ACOs as a new vehicle for clinical partnerships by hospitals and physicians and New Jersey providers have responded with enthusiasm to the opportunity. *Exhibit 7* shows that 17 organizations have formed Medicare Shared Savings Program (MSSP) ACOs in New Jersey since 2012. Most of the New Jersey MSSP ACOs are led by hospitals. While no New Jersey providers formed Pioneer ACOs in the first year of the program, four of the large systems were approved to start as MSSP ACOs in 2012: Atlantic Health, Barnabas Health, Hackensack Physician Hospital Alliance, and Optimus Healthcare Partners. The first three were led by hospital systems while the last one was formed by four physician organizations in Morris and Somerset Counties.

When the results for the first year of operation were released, all of the New Jersey ACOs that started in 2012 and 2013 had achieved the quality benchmarks. But only three of the 10 that started in 2012 or 2013 – the Hackensack Alliance, Meridian ACO, and Optimus Partners – had generated enough savings to receive payments from Medicare. Optimus Partners got the biggest shared savings at \$8.34 million, followed by Meridian ACO and Hackensack Alliance. The Barnabas Health ACO did not generate savings, and neither did Atlantic Health’s ACO. Noting the success of the Optimus Partners ACO, many of whose members practice at Atlantic hospitals, Optimus was invited to take over management of the Atlantic ACO.

Nationwide, of the 220 MSSP ACOs for whom 2012/2013 results were reported, only 46 earned shared savings by reducing costs and also meeting the quality requirements. Looking at the relatively small number of MSSP ACOs that succeeded by achieving better quality care at a lower cost, what can be said about their strategies and characteristics? It was not the case that larger organizations had some advantage, because the smaller ACOs (with less than 8,000 beneficiaries) were more successful in reducing spending. One analysis of the early results in this *Health Affairs* blog post from January 2015 suggested that smaller, physician-led ACOs, like Optimus in New Jersey, “may be better positioned to

transform care delivery more effectively than their larger hospital-led or integrated delivery system ACO counterparts – or at least they may be able to implement changes more quickly.”¹⁹

In interviews, ACO leaders and consultants suggested several factors that contributed to the success of the three New Jersey ACOs that earned shared savings. First was the effective use of patient data and analytics to identify patients that were heavy utilizers of care and to design strategies to work closely with them. Second, the participating physicians and hospitals already had built a significant information technology backbone that linked electronic medical records and already had an effective care management function. They were already following up with patients after hospital discharge and the organizations already had in place programs for sharing data on physician performance and disseminating best practices. Third, the makeup of the participating physicians was more important than the *size* of the physician panel; that is, did the ACO have the physicians that were most capable of providing effective, coordinated care, as opposed to the broadest panel? One successful ACO in New Jersey had a relatively small number of carefully selected physicians (about 300) while another had five or six times that number.

One ACO leader pointed out that a Medicare ACO that generates \$20 million in savings gets back only half of that amount, and so has, in effect, reduced revenues to its providers by \$10 million. Much of the reduction in expenses comes at the participating hospitals, since the doctors are trying to reduce admissions and lengths of stay. Part of the strategy of the ACO’s hospital and physician leaders for countering that is to expand the number of doctors admitting patients to those hospitals, replacing some of the volume that was lost.

Many of the ACO leaders interviewed described their ACOs as a transitional strategy, a way of gaining the experience and skills needed to better manage the health of a population in an environment where providers assume some measure of risk. Those skills include data analytics, care management and discharge planning, and risk management. Part of the reason they view ACOs as a short-term strategy is that it will be harder to continuously generate savings going forward and for the rewards to compensate for investments in technology and systems of care management. In the words of one interviewee, how do you continue to achieve savings after you have already reached a high level of efficiency? As a January

¹⁹ Mark McLellan, S. Lawrence Kocot and Ross White. “Early Evidence of Medicare ACOs And Next Steps for the Medicare ACO Program,” *Health Affairs* Blog Posting updated January 22, 2015. Accessed March 2015 at, <http://healthaffairs.org/blog/2015/01/22/early-evidence-on-medicare-acos-and-next-steps-for-the-medicare-aco-program/>

2015 posting in *Health Affairs* concludes, “further changes will be needed to MSSP to attract and sustain organizations that are effectively reforming care. Many ACOs are seeking more certainty about their financial performance and prospects for savings before committing to a two-sided risk and making larger investments in redesigning care.”

One of the New Jersey Medicare ACOs that started in 2013, Accountable Care Network of New Jersey, was formed as a partnership between Advocare and Walgreens. It is also known as Advocare Walgreens Well Network. Advocare is a large and growing physicians group in south New Jersey with more than 500 physicians. Monthly releases at the Advocare web site announce a steady stream of physicians and clinics joining Advocare. Advocare’s affiliate, Continuum Health Alliance, offers management services to physicians and clinics that want to remain independent. Accountable Care Network of New Jersey did not generate savings in 2013, and Walgreens announced in December 2014 that it would end its ACO partnerships in New Jersey and Texas.

Three of the six Medicare ACOs that began their contracts in 2014 are led by hospitals: JFK Population Health Company ACO in Edison, LHS Health Network, centered around the Trinity/Our Lady of Lourdes providers, and RWJ Partners, including the RWJ University Hospital and physician groups. Nationally, Trinity Health has been very active at launching Medicare ACOs in its different local provider groups. Richard Gilfillan, former head of the Innovation Center at CMS, is the CEO of Trinity Health and an enthusiastic booster of the ACO strategy. He has announced a goal of having an ACO in every one of Trinity’s hospital markets.

Among the ACOs that are led by physicians is Partners in Care ACO, based in East Brunswick. Partners in Care includes an IPA network with 650 participating providers in 14 New Jersey counties and an affiliated health care management company, providing administrative services to a variety of insurers and self-funded employers. Saint Peter’s University Hospital in New Brunswick and its affiliated physicians now participate in the Medicare ACO network.

In addition to participating in Medicare ACOs, many of these provider systems also have similar arrangements with commercial insurers, in which they seek to achieve quality benchmarks and will then share in savings generated through better care management. Health insurers like Horizon, Aetna, and UnitedHealthcare will sometimes provide advance payments to the physicians to pay the cost of adding care coordinators or to enhance electronic medical records or other health information technology. The table shows that most of the hospital systems have entered into these contracts with Horizon Blue Cross

Blue Shield. Some others, like the Hackensack Alliance ACO, have announced contracts with Aetna and other commercial insurers.

Medicaid ACO Demonstration

A number of states have sought to apply the notion of ACOs to their Medicaid programs. By one count, eight other states have already launched Medicaid ACO initiatives, and New Jersey and eight others are in the planning stages to establish their own programs. And while the Medicare ACOs are constructed around hospitals and physicians seeing a large number of seniors, these Medicaid ACOs involve and are sometimes led by providers serving the uninsured and Medicaid populations, including general hospitals, pediatric hospitals, and federal qualified community health centers (FQHCs).

In 2011, the New Jersey legislature authorized a Medicaid ACO demonstration project in which nonprofit organizations would form a network of providers (hospitals, physicians, and behavioral health professionals) to serve Medicaid enrollees in designated service areas. Each of the local ACOs had to get the participation of all general acute care hospitals and 75 percent of the primary care physicians in their service areas. The concept is similar to the other varieties of ACOs, with the providers seeking to improve care management, reduce hospital and emergency room use, and save money compared to past spending. If they succeed, then they would share in those savings. A significant difference between the Medicare ACOs and state Medicaid initiatives is that the most Medicaid recipients in the state are now enrolled in Managed Care Organizations (MCOs), while the Medicare Share Savings ACOs are specifically limited to seniors who are not enrolled in Medicare Advantage plans. In New Jersey it was expected (though not required) that each of the local ACOs would contract with the Medicaid MCOs in that area to collaborate to improve care delivery and coordination and for the MCOs, in turn, to share the savings or gains with the ACO and its providers.

Much of the impetus for New Jersey's Medicaid ACO program and key elements of the program design came from the Camden Coalition of Healthcare Providers. That group has won national attention for its "hot spotting" initiatives, where it mapped areas of the city where persons were frequent utilizers of hospital emergency rooms and matched them with a variety of resources to better coordinate their care and improve their housing and employment situations. The goals are to reduce hospitalization, improve

care and health status, and save money in the process.²⁰

Although the Medicaid ACO demonstration was authorized in 2011, it has not launched as of this writing. Promulgating administrative rules for the program took a long time. In mid-2014, eight organizations submitted proposals to the Division of Medical Assistance and Health Services to participate in the program, and they are listed in *Exhibit 8*. One organization, Coastal Healthcare Coalition of Atlantic County, later dropped out. The Division requested additional information in December of 2014 and is still examining the adequacy of the physician networks of the proposed ACOs. As of this writing, the state has not certified any of the applicants, but expects to do so later this spring and fully launch the program in the summer of 2015. In the meantime, at least one of the proposed ACOs, the Camden Coalition, was given permission to negotiate with MCOs on the terms of their relationship and gain-sharing. It has reached gain-sharing agreements with UnitedHealthcare Community Plan and Horizon NJ Health, the two largest Medicaid MCOs in its service area. The Camden Coalition already had arrangements with those two MCOs for incentive-based payments tied to quality measures and for advanced payments so that the Coalition could hire additional care coordinators.

NEW WALK-IN CLINICS

In the past five years, dozens of new walk-in clinics have opened in many parts of the state. These clinics are responding to and capitalizing on a demand for convenience that traditional medical clinics usually are not offering. This research looks at two kinds of walk-in clinics, retail clinics and urgent care clinics. Based on research for this project conducted in the first three months of 2015, there are 217 urgent care clinics operating or scheduled to open in 2015 in New Jersey. And there are 43 retail clinics operating or scheduled to open in 2015.

A third category of convenient care alternatives is the freestanding emergency room, of which there are now two in the state. Both were developed in response to the closing of a local hospital, leaving their communities some distance from emergency services. One is run by the JFK Health System, at the site of the former Muhlenberg Regional Medical Center in Plainfield, which closed in 2008. The second one was developed by the AtlantiCare system in Hammonton after the Kessler Memorial Hospital closed in 2009. By state rule, a freestanding (or satellite) emergency room is an extension of an existing hospital and its

²⁰ See, for example, this article by Atul Gawande, “The Hot Spotters,” *New Yorker*, January 24, 2011.

Accessed in March 2015 at <http://www.newyorker.com/magazine/2011/01/24/the-hot-spotters>

license. They are typically staffed seven days a week, 24 hours a day and offer, on-site imaging, laboratory, and other services, such as emergency mental health treatment.

Urgent care and retail clinics are similar in several ways. They both offer walk-in, same-day access without requiring an appointment. Both have extended hours and are open evenings and on weekends. (A few are only open evenings and weekends.) They provide episodic care and are generally not seen as primary care homes, referring patients back to their own primary care clinics, if they have one, or to affiliated full-service providers for management of chronic conditions and other ongoing care.

There are also important differences between the two in areas such as staffing. A retail clinic is staffed by a nurse practitioner, and an urgent care clinic is staffed with at least one physician, as well as nurses and mid-level practitioners like physician assistants and nurse practitioners. An urgent care clinic also has imaging and laboratory services on site. The Cooper University system rotates emergency room physicians through its three urgent care clinics while the three Virtua Health urgent care clinics (and likely most others) are staffed by family practice physicians.

Two other differences relate to ownership. First, the retail clinics here and nationally are very concentrated in their ownership. Out of the 43 retail clinics in New Jersey, all but nine are Minute Clinics owned by CVS. Walgreens operates three Take Care Clinics in stores in south New Jersey, and there are six clinics in ShopRite supermarkets in central and southern New Jersey. The ShopRite clinics are operated by local provider organizations, such as CompleteCare Health Network, a large FQHC in south New Jersey with three ShopRite locations, and St. Francis Medical Center with two store clinics in the Trenton area. Cooper University Health opened a clinic in a ShopRite store in Marlton.

Retail clinics generally have an affiliation with a local provider system for referrals for care beyond the menu of services provided at the clinic or because the nurse practitioners at the retail clinic must have a collaborative relationship with a physician licensed in that state. CVS Minute Clinic posts that clinical affiliation on the individual web page of most of its New Jersey clinics. It has clinical affiliations with at least six provider systems in New Jersey. In Morris County, where CVS has opened six Minute Clinics, Atlantic Health System is the clinical affiliate. (There are more retail clinics in Morris County than any other county in the state.) In Burlington, Camden, and Gloucester Counties, where it has six Minute Clinics, Virtua Health is the clinical affiliate.

Partly to strengthen interactions with its clinic affiliates around the country, CVS is implementing Epic

Systems electronic medical records across its clinic locations. That is a significant investment for a provider where the average charge for an office visit is often less than \$50. A consultant in this area suggests that the move to Epic is intended to strengthen ties to local provider systems and to signal a commitment to becoming an integral part of a community's health care infrastructure.²¹ One example of how Minute Clinic is strengthening ties to local provider systems can be seen in its growing relationship with the Emory University health system in the Atlanta area. They first announced in 2011 that Emory would be the clinical affiliate for the Minute Clinics in the Atlanta area, that Emory doctors would be the medical directors for each clinic, and that Minute Clinic and Emory would share medical records for patients seen at Minute Clinics. In a recent move to bring the two systems closer, Emory patients will be offered appointments at local Minute Clinics for certain kinds of health screenings for chronic conditions. For example, patients diagnosed with hypertension may be referred out to local Minute Clinic locations for periodic blood pressure checks, the results of which are immediately entered into the patient's electronic medical record in the Emory system.²²

Exhibit 9 shows the distribution of urgent care and retail clinics by county and region. It further divides urgent care clinics into two categories: those owned by hospital systems and physician groups and those owned by private companies. There are retail clinics in most counties in the state, with the largest number in Morris County. Four other counties have four retail clinics: Bergen, Burlington, Gloucester, and Mercer. Statewide, about one-fifth of all urgent care clinics are owned by hospitals or by large group practices such as Summit Medical Group. In southern New Jersey, hospitals and groups own almost 40 percent of the urgent care clinics.

Exhibit 10 lists the largest urgent care companies in the state based on the number of clinics and breaks out that number by region. MedExpress is the largest urgent care clinic operator in the state, with 18 clinics and a presence in all three regions. In April 2015, UnitedHealth Group's Optum company announced that it would acquire MedExpress, the third largest urgent care clinic company in the country, with about 140 clinics. In recent years, Optum has acquired medical practices and independent practice associations in multiple states. A month earlier, by coincidence, Concentra, Inc., the largest urgent care clinic operator in the country, was sold by its owner, Humana. Much of Concentra's business is in workers' compensation, but its clinics are also open to the public. Concentra was purchased by a joint venture of Select Medical, a national provider company, and a private equity company.

²¹ Interview with Thomas Charland of Merchant Medicine, February 9, 2015.

²² Presentation by Tobias Barker, MD, CVS Minute Clinic: "Use Cases for Telemedicine in the Retail Health Space," American Telemedicine Association Annual Meeting, Los Angeles, CA, May 4, 2015.

Tied with Concentra for second largest in New Jersey is AFC/Doctors Express, a company formed by a merger in 2014, which also has 13 clinics in New Jersey, mostly in the northern and central regions. Some New Jersey provider systems are active in developing and operating urgent care clinics. AtlantiCare Urgent Care in southern New Jersey is among the four largest urgent care operators. Valley Medical Group in the area around Ridgewood operates seven urgent care clinics. Other provider systems operating urgent care clinics are Inspira and Meridian Health, both with five clinics. Virtua Health in southern New Jersey currently operates three urgent care clinics and plans to open two more in 2015. It placed two urgent cares inside the wellness centers it owns in Sewell and Moorestown.

Why are many New Jersey provider groups opening urgent care clinics? One key reason is that they are seeing a shift away from payment based on filling beds to managing the health of a population within a given budget. Operating urgent care clinics creates an opportunity to divert inappropriate emergency room visits to a less expensive setting. A second reason is that establishing new urgent care clinics is part of an overall strategy to extend the geographic reach of those systems into developing, more affluent areas, where the payer mix is likely more favorable, with more families with good commercial coverage and fewer that are uninsured or on Medicaid. In some cases, establishing urgent care clinics (or physician offices or wellness centers) at some distance from the system's hospitals is also a way of challenging competitors on their own turf.

The expansion of Medicaid eligibility in New Jersey has added 420,000 more Medicaid enrollees since the beginning of 2014, or a total of 1.7 million recipients, with 92 percent of them enrolled in one of five MCOs. That growth has raised questions about whether there is adequate primary care capacity for current and new Medicaid recipients. Might retail and urgent care clinics be used more widely to provide additional capacity?

For several reasons, it does not appear that urgent care or retail clinics are likely to supply significant new primary care capacity for Medicaid recipients. First, the payment rates for Medicaid patients in New Jersey are generally too low to be appealing to convenient care clinic operators. One of the obstacles to gaining additional physicians participation on Medicaid is that Medicaid payments to physicians are generally about half of what physicians receive for caring for Medicare recipients.²³ Representatives of

²³ Based on Kaiser Family Foundation data accessed at: <http://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/>. The comparison is based on New Jersey's fee schedules for enrollees not served in Managed Care Organizations. The Managed Care Organizations can and do negotiate higher fee schedules with physicians and hospitals.

providers said that it is very difficult to get more physicians, particularly certain specialists, to accept Medicaid patients because the state's payment rates are so low.

The ACA provided additional funding for states to increase their Medicaid payments to primary care providers for two years. New Jersey did implement the enhanced payments, although that did not occur for several months into the fiscal year. Physicians viewed the enhanced payments with some suspicion, expecting that they would disappear in a short time. Recently reported research concluded that the enhanced payments provided to primary care providers under the ACA did improve access to care for Medicaid recipients by opening up more appointments.²⁴ But the research did not address whether or not additional doctors agreed to accept Medicaid recipients, and a separate report from The Medicaid and CHIP Payment and Access Commission concluded, based on a survey of state Medicaid officials and MCO leaders, that the payment increase generally had "little to no effect on provider participation rates in Medicaid".²⁵ Federal funding for enhanced primary care payments ended at the end of federal fiscal year 2014, although it was reported that Governor Christie's budget proposal would continue part of the enhanced payments.²⁶

The second reason that it is unclear that these clinics would provide significant additional capacity for Medicaid enrollees is an apparent lack of interest by MCOs. In interviews with the major health plans, they said that they are generally contracting with urgent and retail clinics as network providers and covering episodic care received in those settings. Further they said they were open to more frequent use of those clinics by any of their enrolled groups and individuals. However, none of those interviewees said they were looking to retail or urgent care clinics as primary care homes and that working with primary care medical homes was key to their strategy of managing care for Medicaid recipients and other insureds. For one thing, those clinics generally are not equipped to provide or interested in providing the range of primary care services that are needed to act as a medical home. CVS, which is the largest operator of retail clinics in the country, has been clear that it does not intend to expand its menu of about 20 services much in the near future and certainly not to such an extent that a clinic could be a full service

²⁴ Polsky, D., M. Richards, S. Basseyn, et al. 2015, "Appointment availability after increases in Medicaid payment for primary care." *New England Journal of Medicine* 372: 537–545.

²⁵ MACPAC, "An Update on the Medicaid Primary Care Payment Increase," March 2015. Accessed at <https://www.macpac.gov/wp-content/uploads/2015/03/An-Update-on-the-Medicaid-Primary-Care-Payment-Increase.pdf>

²⁶ See Kathleen O'Brien, "Christie budget aims to ease Medicaid doctor shortage," in NJ.Biz, published February 24, 2015. Accessed March 2015 at http://www.nj.com/healthfit/index.ssf/2015/02/christie_budget_aims_to_ease_medicaid_doctor_short.

primary care provider. Most of the net growth in retail clinics nationally has come at Minute Clinic, which added 156 clinics in 2014 and now operates almost 1,000 clinics in 32 states.²⁷

Other retail clinic operators have expressed strong interest in playing a larger role as primary care providers. Walgreens, the second largest retail clinic operator in the country, announced its intent in 2013 to expand its menu of services and become a convenience care provider that can also diagnose, treat, and manage chronic conditions like diabetes, asthma, and high cholesterol. Walgreens said in its announcement that it does not seek to take over primary care, but to provide more access points to patients needing care.

In other states, health plans and provider organizations are developing retail store locations for full service clinics. Target, which does not have clinics in New Jersey now, has announced a partnership in California where Kaiser Permanente will operate Kaiser clinics in stores there and that those clinics will provide a broader range of services, including diagnosis, treatment, and management of chronic conditions. The clinics will be staffed with nurse practitioners and Permanente Medical Group doctors will be available for phone consultations. Wal-Mart currently has clinics in some of its stores in 18 states, operating as “the Clinic at Walmart.” For each, it contracts with a local provider system to manage the clinic and employ the providers. And it has started a new in-store clinic initiative called CareClinic. Those clinics focus on offering low-priced care to Walmart employees, again using local provider systems.

Two other reasons why health plans in New Jersey do not seem inclined to use convenient care clinics as medical homes. If they did, they are concerned that other physicians and groups currently in the network might push back on the health plan if they were concerned that these clinics, both retail clinics and urgent cares, would take over their patients, not just see them for an occasional episode of ear infection or sprained ankle when the primary care clinic was not open or had no open appointments. Two national associations of primary care physicians have issued statements opposing retail clinics, saying that they are more likely to disrupt continuity of care and to misdiagnose because they are responding to a complaint rather than trying to view the whole patient.

Finally, MCO leaders looking at expanded use of convenient care clinics as primary care providers see a geographic mismatch in where the new convenient care capacity is being added and where families

²⁷ Merchant Medicine, “The ConvUrgentCare® Report,” January 2015.

covered by Medicaid live.²⁸ By design, walk-in clinics are usually located in areas where the population is of higher income and where they fit in with retail stores, with their high traffic and evening and weekend hours. Looking at zip codes in Camden and Burlington Counties as an example, it is clear that retail clinics and urgent cares are located in zip codes with higher household income, not usually areas that have a shortage of health providers or a high number of Medicaid recipient households. For example, the average household income in zip code 08103 in Camden, where Cooper University Hospital is located, is \$21,888, according to the American Community Survey data, and the average in zip code 08102, where the Project Hope health center is located, is \$18,696. There are two Minute Clinics in Cherry Hill: one in zip code 08003, where the average household income is \$109,752, and the other in zip code 08034, where the average income is \$86,859. There are no urgent care or retail clinics in the city of Camden. Cooper has established three urgent care clinics in suburban areas – Audubon, Cherry Hill, and Winslow Township, and a retail clinic in Marlton. Again, the household income in those places is far higher than in Camden.

CONCLUSIONS

The initiatives of the ACA and other market trends have created significant opportunities for provider systems, but also stress and uncertainty. On the one hand, many people who were formerly uninsured now have coverage through the Medicaid expansions or have bought individual coverage, reducing the uncompensated care burden for those providers. At the same time, many of the newly insured and those in employer groups are in benefit plans that impose significant cost-sharing requirements, sometimes creating collection problems for those providers or discouraging individuals from accessing care.

This report has described a series of strategies that New Jersey health providers are pursuing. Many provider systems, for example, proceed from an assumption that “bigger is better,” and some seek to grow their systems through mergers with or acquisitions of other hospitals and provider groups. Other seek to expand their networks of primary care providers, both in number and in geographic reach, and are employing more physicians and opening convenient care clinics outside of their core service areas. Some are forming strategic partnerships with local providers, such as ACOs for Medicare and Medicaid, while others seek to add the marketing power of affiliations with nationally known or regionally significant provider systems, such as the partnerships with M.D. Anderson, Cleveland Clinic, or Children’s Hospital

²⁸ Note that MCOs in New Jersey and elsewhere already work closely with some of the key providers that are in those zip codes, namely Federally Qualified Health Centers (FQHCs). A few FQHCs have added weekend and evening hours and staffing and promote their care sites as urgent care clinics.

of Philadelphia. The future of clinical affiliations between local provider systems and convenient care clinics is intriguing, particularly as those systems look for ways to provide care in less expensive settings.

The uncertainty faced by providers results from the lack of clarity about which of these strategies will be successful and rewarded and which might face regulatory opposition or may have positive results in the short term but are not a recipe for long-term success. In several other states, for example, the FTC has opposed provider acquisitions or mergers, charging that they would result in higher prices as locally dominant provider systems use their market power to raise prices to health plans and employers.

None of the recent hospital transactions in New Jersey have been opposed by the FTC or other regulators. And, because the most recent proposed deals (Hackensack and Meridian) are not operating in the same local markets, at least as that term is currently understood, it is not likely that they will face serious objections. As was shown above, even in those areas where there is the most merger activity, the combined system will still have a market share below the informal threshold that would trigger regulatory opposition.

As was discussed above, the notion of what constitutes a local market is changing, as recent proposed mergers cross historic regional boundaries within a state as well as state boundaries, as evidenced by Geisinger Health's acquisition of two Atlantic City hospitals. And some of the limited network or tiered network design strategies used by health insurers, both inside and outside of health insurance exchanges, have given insurers some additional leverage in their dealings with large provider systems. In effect, merging provider systems can argue that their market power has been eroded by those developments.

For that and other reasons, it is likely that large provider systems in New Jersey will pursue new mergers or acquisitions in the near future. Smaller hospitals are uncertain about whether they can make the investments in IT systems or can establish a large enough base of patients in the future. Even if they have a strong geographic advantage in an area that is somewhat affluent, independent community hospitals often find it difficult to remain autonomous or to raise the capital needed to make investments needed to remain competitive. Some are concerned by what some analysts call the "musical chairs" problem, which is that they fear that they will be the last independent hospital after all the others have entered into larger systems. Larger hospitals or systems are concerned about when they will be big enough to ensure their future success.

Another strategy whose long-term impact and sustainability is unclear is the formation of ACOs and other

kinds of limited risk arrangements for providers. Many New Jersey providers have formed ACOs, anticipating that they will need to transition soon to payment systems in which payment is no longer tied to the volume of procedures and inpatient hospital days. But as was discussed above, even the three New Jersey ACOs for Medicare that have successfully saved enough money to share in savings have raised questions about how long new savings can be achieved and whether the revenues lost can be offset by efficiencies or success in expanding the patient and provider base.

Some have suggested that if limited risk arrangements like ACOs are only a transitional strategy, that some of these provider systems will seek to assume additional risk, whether by forming their own insurance companies or by entering into risk arrangements with insurers. One New York hospital system, North Long-Island Jewish, has established its own health insurance company and has reportedly had discussions with New Jersey providers about joining its provider network on some basis. Earlier, it was noted how some New Jersey provider systems have experimented with those kinds of arrangements with insurers.

Yet that strategy raises a *déjà vu* concern for provider systems and others that recall how provider systems pursued similar risk-assumption strategies in the 1990s, whether through accepting full-risk capitation contracts or forming their own health insurance plans. Many of those ventures were shut down within a few years for a variety of reasons. First, the anticipated shift to a fully capitated market never materialized. Second, hospitals and physicians found that they had fundamental conflicts with their in-house insurer companies and that those conflicts about payment and care management could not be satisfactorily resolved. And third, the provider owners sometimes despaired that they could not compete effectively against large national insurance companies that could offer large national employers the administrative simplicity of dealing with a single health plan across multiple sites.

Whether or not the ACO as a vehicle for health systems will last into the future, provider systems are shaping their strategies around an expectation that payment arrangements and incentives in the future will necessitate approaches to expand their patient base, to have additional points of presence and to provide care in less expensive settings. That is a major reason for the amount of convenient care development by certain provider systems. For many New Jersey provider systems and for CVS, the largest operator of retail clinics, it appears that their approach to convenient care is that it creates new points of presence and additional convenience for patients, hopefully keeping them within or bringing them into that provider system. But it does not appear that these clinics will play a significant role in improving access for Medicaid recipients.

In summary, the changes and strategies described in this report reflect a high degree of uncertainty about both the underlying assumption of what the future holds and the likelihood that those strategies will be successful and sustainable in the future. Whether providers will be invoking a “bigger is better” mantra in the future and betting the future of their organizations on it also remains to be seen.

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About the Author

Allan Baumgarten is an independent research consultant whose work focuses on health care policy, finance and local market strategies. He works with a variety of organizations to help them analyze the market competition and policy issues they face and to develop business strategies to meet the challenges of dynamic markets and health reform. His clients include health plans, provider organizations, government agencies and manufacturers of pharmaceuticals and other health products and services. For more information, visit <http://www.allanbaumgarten.com>.

APPENDIX 1**Listing of New Jersey Counties by Region**

These are the counties grouping used by the New Jersey Department of Health and in this report in analyzing market share by region. For the most part, the Northeast and Northwest county groups were combined.

Central

Hunterdon
Mercer
Middlesex
Monmouth
Ocean
Somerset

Northeast

Bergen
Essex
Hudson
Morris
Passaic
Union

Northwest

Sussex
Warren

South

Atlantic
Burlington
Camden
Cape May
Cumberland
Gloucester
Salem