BREAKTHROUGHS:
Hospital Merger and Acquisition Strategies

Case Study | Baylor Health Care System
Dallas knows big. Whether it is the busiest airport in America or the largest domed stadium, the scales used to judge relative size in Dallas often tip in favor of unbridled enormity. The same does not necessarily apply to hospital system growth for the leaders at Baylor Health Care System.

Make no mistake that Baylor Health Care System is huge—with 26 hospitals that are either owned, operated, or in a joint venture partnership, along with 21 ambulatory or endoscopy centers and 31 outpatient locations spread across the 10-county Dallas "Metroplex" area. In all Baylor serves nearly 1.4 million patients a year with annual operating revenue of $3.4 billion. But growing in a vacuum is not part of the health system’s strategic plan, says president and chief executive officer Joel Allison.

“We want to grow appropriately in order to meet the needs of the patients and communities we serve,” Allison says. “It’s not what I call an aggressive ‘grow-for-growth’s sake’ plan. It’s very deliberate, and it’s very much a planned coordinated process that makes sense around our mission, our vision, and our values.”

How to grow “appropriately” is a complicated question in the Dallas area. The demographic projections that Baylor is using show that the 10-county area could double by 2025 to approximately 12 million residents. In order to meet that need for medical services, Baylor Health Care System has a merger and acquisition plan built alongside opportunities for “green field” growth of both inpatient and outpatient capacity, says chief operating officer Gary Brock.

With a capital budget next year of $515 million, Brock says that he could spend every dollar—and so could primary market competitors Texas Health Resources and HCA, Inc.—and “still not meet the growth of the Metroplex’s healthcare needs.” Beyond the need for meeting market growth, Baylor must acquire or build to keep spreading costs. For a system the size of Baylor, that fuels a sizeable growth imperative.

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Baylor Health Grows With Community Need
“Growth is a huge, important part of what we have to be about,” Brock says. “We can’t get enough cost out to overcome the $80–100 million this year we’re going to have just from inflation and due to increased costs of utilities, labor, pharmaceuticals, and blood and the different expense components that we’re trying to cover.” Baylor spends 16.4 cents of every dollar on supplies, slightly more than a national benchmark of 16.1 cents, Brock says. The system spends 47% of net revenue on salaries, wages, and benefits, versus a national benchmark of 53%. Systemwide Brock says Baylor is 1,600 FTEs below suggested case mix index. So as far as the 73% of costs that are controllable—operating expenses that are related to Baylor’s salaries, wages, benefits, and supplies—Brock says “we’re at the top of our game.”

“I’ve got a lot of fixed costs in IT and billing systems, so I can acquire a facility or take on growth of a new hospital and spread some of that fixed corporate cost against some of those facilities and reduce my costs for the other facilities that we have,” Brock says. “So that’s a big, important piece of growth.”

Growth allows Baylor to spread the 10% of corporate administrative operating costs over more units, but to achieve gains in quality and finance requires the new pieces to adopt “the Baylor way,” which includes centralized administrative leadership, with local hospital trustees converted to local advisory boards, and hospital presidents who “work through influence, not control,” Brock says. The same structure works for all operating units of the hospital, he says. “We’ve moved from a holding company to an operating company model, and to where everything from administrative functions and clinical oversight is driven from a central perspective,” Brock says. “So I have vice presidents of pharmaceutical service, lab services, radiology services that the directors out in the field report to. They don’t report to the local entity directly, and so for instance we drive pharmaceutical strategy, compliance, quality, safety and reliability, efficiency from a system perspective. There’s no opting out. We don’t have individual governance in these hospitals.”

Merger mania
Dallas-Fort Worth is, in some ways, farther along in mergers and consolidation than many metropolitan statistical areas. Texas Health Resources was formed by the merger of Presbyterian Healthcare System and Harris Methodist Health System in 1997

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Joel Allison, CEO, Baylor Health Care System
and now numbers 13 hospitals. Merger talks between Baylor Health Care System and Texas Health Resources were announced after THR's creation to create one large megasystem, but were later abandoned. Baylor continued on an acquisition and building strategy for inpatient market share.

In 2004, Baylor Regional Medical Center at Plano opened with 96 beds, increasing to 128 in 2007. Also in 2007, the Heart Hospital at Baylor Plano opened as a joint venture with a local cardiovascular group. In 2009, Baylor purchased a 71 percent controlling interest in the operating company of the 237-bed former Trinity Medical Center in the northwest Dallas suburb of Carrollton, with local physicians owning the other 29 percent. The hospital itself is owned by a local government authority charged with providing hospital services in several area communities, with the Baylor and physician partnership signing a long-term lease to operate the hospital. In this case, the partnership and merger fit the plan for growing in the market, without the need for new development, Brock says.

"It's in Denton County, which is a county that's north of Dallas County, and so it's got capability of around 180 beds, and it was a facility running an average daily census of less than 100. We felt it was in a good market in terms of socioeconomic areas, trade, and traffic pattern areas." With Baylor hospitals in nearby Frisco and Plano, the Carrollton merger "really fit within that corridor and kind of filled out our organization to the north."

Acquisition can't fill all the holes in a growing Dallas marketplace, so Baylor is building a new $212 million hospital in rapidly growing McKinney north of Plano that will open in 2012.

Allison says the determination about whether to build or partner is based primarily on what the community itself wants or needs, be it to build a hospital in McKinney or acquire a lease in Carrollton.

"Maybe the need is just around a clinic, a physician's office, or imaging centers," Allison says. "Perhaps the market in that community needs an ambulatory surgery center. They may not need a full service hospital, but they need and they want Baylor and Baylor physicians, so we look at those models that truly meet the needs of those communities." Beyond pure bed capacity, Baylor is aggressively building its capability within key service lines. The 10-story, $350 million hospital in McKinney is expected to open in 2012.
million Baylor Charles A. Sammons Cancer Center will open at the flagship Baylor University Medical Center’s central Dallas campus in March 2011. Baylor also noted that many patients were traveling to Houston for neurosciences, so the system invested in gamma knife, cyber knife technology, and inter-operative MRI. Baylor expanded its capacity for neuro intensive care and inpatient floor space, which not only boosted neurosciences at the university medical center but also grew the referral streams in the community hospitals, Brock says.

**Physician churn**

Dallas physicians, like many of their counterparts nationwide, are placing their bets that a reimbursement climate that favors systemness will push them back under the umbrella of hospitals and health systems. Baylor has announced it will convert its 4,500 physicians to an accountable care organization by 2015. But the push toward growing the strength of Baylor’s physician alignment still falls under a carefully crafted plan, Allison says.

“What we look for whenever we do these kinds of arrangements is a cultural fit, and we try very diligently to do a cultural assessment to be sure,” Allison says. “We’ve got to say we lead with our physicians. We believe in strong physician partnering. And so if there is not a cultural fit there, we’re not going to push the agenda.”

Michael Taylor, senior vice president of operations, says that sometimes even when there seems to be a cultural fit and physicians welcome Baylor into their community, they may underestimate the amount of change they need to meet the benchmarks required in the deal. But beyond the quality measures Baylor tries to find flexibility to work with physicians in multiple alignment scenarios.

“Physicians aren’t any different than the rest of us in that they prefer choice,” Taylor says, “and individual fit is key. They can find a relationship choice, whether it’s employed or private practice, in a partnership or not in a partnership. That said, the responsibility to meet the quality criteria and participate actively in ongoing improvement and patient assessment, and what we call the ‘service excellence-patient satisfaction perspective’ is foundational, not a choice.”

**Big Tex healthcare**

Whether it is physicians or hospitals, what Baylor acquires in the coming years will be based on growing its capacity to scale quality of care and coordination. Beyond bed space and physicians, Baylor is also looking to either acquire or contract with the other pieces of the ACO puzzle it may need, including home and post-acute care. The drive toward growth and coordination is not limited to the Dallas area alone. Allison and others recognize that scale may come with larger affiliations with providers and payers that could cover more of the Lone Star state.

“I wouldn’t say we are totally limited by the 10 counties,” Allison says. “I think we will be looking more regionally, particularly when a payer may come and say they need a broader network.” Baylor is among those in discussions with the Texas Employee Retirement System and its health plans on coordinated care delivery, he says. “So if you’re going to look at those opportunities and you’re going to have to partner with other systems and look at going beyond your current geography and become more regional, and I think eventually, statewide in some type of relationships, that’s the opportunity that’s before us.”
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