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Consolidation Of The Inpatient Medical Rehabilitation Industry

Market forces continue to work in this hospital sector. Does this serve the public interest?

by Ben Wheatley, Gerben DeJong, and Janet Sutton

One of the sentinel trends in American health care is the accelerating pace of mergers and acquisitions among health care providers and payers. Among providers, large investor-owned hospital companies are absorbing smaller, less organized providers to form nationwide multimarket chains. Fueled by Wall Street capital, these firms have set the pace in retooling health care capacity and delivery in the face of managed care’s relentless demands for price concessions and cost control.

In the acute care hospital sector, Columbia/HCA built up significant capacity before being hit by its well-publicized legal difficulties in 1997. Tenet Healthcare is now moving into position to become the dominant hospital provider in the United States, with facilities located throughout the nation. Less well known is the postacute care sector, which also is undergoing rapid consolidation. HealthSouth Corporation has become the leading consolidator in the medical rehabilitation hospital industry, now operating 54 percent of the nation’s 194 freestanding rehabilitation hospitals.

This paper examines mergers and acquisitions in the medical rehabilitation hospital industry and seeks to identify the leading factors driving this consolidation. We consider whether health care consumers and the public interest, broadly defined, are well served by current trends and discuss steps that the federal government has taken to maintain competition within the industry. We believe that the consolidation of the inpatient medical rehabilitation industry, although unique in many respects, offers an important glimpse into the issues that deserve closer scrutiny across the spectrum of American health care. The developments are emblematic of the slicing of the health care industry into focused niches, each with dominant players and strategies.

The Medical Rehabilitation Industry

In recent years the medical rehabilitation industry has emerged from its relative obscurity and has become more widely recognized as an essential component of health care’s continuum of services. Driven by increasing demand, the industry is expected to grow by 10–12 percent over the next several years. The pool of potential rehabilitation consumers is expanding, principally because of the aging of the population and medical advances that have increased both life expectancy and the prevalence of functional disability. As baby boom-
ers begin to retire early in the next century and medical advances continue, the demand for rehabilitation services may increase even more rapidly.

■ OVERVIEW. Medical rehabilitation provides restorative services to persons who acquire an impairment—because of a congenital condition, a traumatic injury, an acute illness, or a chronic health condition—that limits their ability to function independently. Through an array of services such as physical, occupational, and speech therapy, rehabilitation enables persons with disabling conditions to manage their own daily needs and, whenever possible, return to an active and productive lifestyle. These services are provided in a variety of settings, including freestanding rehabilitation hospitals, acute hospital–based rehabilitation units, and, increasingly, alternative settings such as subacute care units, outpatient rehabilitation centers, skilled nursing facilities, and the home.

Medicare has traditionally been the primary payer for rehabilitation services, accounting for more than 65 percent of inpatient days in the early 1990s. In 1983, when prospective payment based on diagnosis-related groups (DRGs) was introduced into Medicare, rehabilitation was largely exempted. The industry continued to receive cost-based reimbursement, subject to limits prescribed under the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Unlike DRGs, TEFRA limits established site-specific reimbursement ceilings based on costs at a particular facility during a base year, rather than on particular diagnoses.

Although acute care providers were beginning to adapt to tighter Medicare payment rates in the 1980s by decreasing inpatient use and reducing capacity, inpatient rehabilitation capacity continued to grow into the early 1990s. From 1985 to 1989 the number of freestanding rehabilitation hospitals increased by an average of 21 percent per year, and the number of rehabilitation units increased by an average of 17 percent per year. By contrast, the total number of community hospitals decreased at an average annual rate of 1 percent during that same four-year period.

■ RECENT TRENDS. The growth in inpatient rehabilitation has come to an end in recent years as managed care penetration has increased. Capitated physician groups are using inpatient rehabilitation settings much less extensively, and many hospital-based rehabilitation providers have struggled financially as a result. Overall, lengths-of-stay in acute inpatient rehabilitation settings declined by seven days on average between 1990 and 1994. From 1994 to 1995 the total number of rehabilitation hospitals nationwide fell from 172 to 171. Meanwhile, there has been a rapid increase in the demand for alternative settings of care that are both less intensive and less costly.

The impact of managed care on the rehabilitation industry has not yet reached its peak, however. Only 15 percent of Medicare beneficiaries are now enrolled in health maintenance organizations (HMOs), but this figure has been increasing rapidly. In places such as southern California where managed care penetration is high, HMOs have been able to attract elderly subscribers by offering expanded benefits and lower out-of-pocket costs. The elderly population offers HMOs a market opportunity that, at this point, is largely untapped. Moreover, given the imbalances in Medicare’s projected finances, the government is likely to encourage more seniors to join managed care plans. Such a transition would undoubtedly have a significant impact on the rehabilitation industry.

In 1997 the reimbursement landscape for rehabilitation changed dramatically when Congress enacted a prospective payment system (PPS) for rehabilitation providers start-
ing in 2000. The legislation will allow the Health Care Financing Administration (HCFA) to establish prospective payment rates that are based not on DRGs but on case-mix groups that reflect differences in patients’ ages, functional capabilities, comorbidities, and other factors. This shift may lead to further reductions in hospital-based rehabilitation and increased demand for alternative settings of care.

The rapid changes in the financing of health care are now spilling over to the once-shielded rehabilitation industry. The move toward managed care and prospective payment in the postacute sector has produced a slowdown in growth in the industry, and many inpatient rehabilitation providers have had to initiate painful downsizing. Nevertheless, increasing demand will ensure that rehabilitation remains a viable industry for years to come.

**Mergers and Acquisitions**

During rehabilitation’s heady period of growth in the 1980s, inpatient providers were able to improve their competitive position by building or acquiring new facilities and by offering enhanced amenities. Cost-based reimbursement from Medicare and from commercial insurers made amenity-based competition affordable for these institutions. However, this arrangement was unattractive to the growing number of cost-conscious managed care payers. As a result, much of the recent growth in rehabilitation capacity came to be viewed as excessive. HMOs looking for price concessions began to use alternative settings such as subacute care facilities much more extensively. Formerly secure freestanding rehabilitation hospitals suddenly became vulnerable to volume reductions and large revenue shortfalls.

Inpatient providers have had to search for ways to adapt to these conditions. Many of them, anticipating the continued expansion of managed care and increased competition from investor-owned chains, have concluded that networking and system building offer the best hope for survival. As the popularity of this idea has spread, so has consolidation within the hospital industry.

There are two fundamental benefits that struggling independent providers have sought to obtain through networking and system building. First is an increase in market share and leverage. Believing that there is strength in numbers, providers have aligned their capacities to offset the power of rivals and enhance their ability to secure managed care contracts. Second, networking and system building are believed to generate important economies of scale, primarily reduced administrative overhead and bulk purchasing of supplies. As insecurity over market position and the need for cost containment have spread, the number of formerly autonomous institutions that have joined networks and systems has increased markedly.

**Accelerated Acquisition Strategies of For-Profit Chains.** The fear of competition from investor-owned hospital chains has contributed to the changing landscape of the health care delivery system. Not-for-profits have learned to behave in ways that are similar to the behavior of their for-profit competitors. One difference, however, is that proprietary hospital chains must produce continuous growth and increased returns on investment for shareholders, who can easily withdraw their financial support if these expectations are not met. Consequently, these hospital chains are constantly looking for opportunities to increase their revenue margins, and this has contributed to accelerated merger and acquisition activity.

Horizontal integration provides numerous potential advantages (although the empirical evidence has not always borne these out). The most obvious of these, as mentioned earlier, is the potential to achieve economies of scale. Rather than having functions such as accounting and legal work performed at each facility, many hospital operations can be centralized. A national system also can disseminate information about best practices and implement changes that aim to enhance operating efficiency at each local facility. In addition, national systems can offer managed care organizations and large self-insured corpora-
tions an opportunity for one-stop shopping—a means to reduce the expense of negotiating and administering multiple provider contracts. Moreover, systems can achieve brand-name recognition that may increase the likelihood that they will be included in contracts with large payers.\textsuperscript{15}

Despite these potential advantages, some observers have been puzzled by the eagerness of provider systems such as HealthSouth to purchase additional hospitals in an environment in which the demand for inpatient services is in significant decline. One possible explanation is that although inpatient facilities are becoming less the focal point in the overall continuum of care, they still remain an essential component of it. In addition, struggling independent rehabilitation hospitals and hospital chains have produced extremely attractive buying opportunities for those companies still looking to expand. In many instances, the opportunity to establish a dominant position in local markets has come at a very modest price.

\textbf{Rehabilitation’s Leading Consolidator.} Through its rapid expansion, HealthSouth has emerged as the leading consolidator in the inpatient rehabilitation hospital industry. In 1996 HealthSouth became the second public company to own and operate health care facilities in all fifty states.\textsuperscript{16} It now owns more than 1,600 facilities throughout the United States and has begun acquiring facilities in Great Britain and Australia.

Founded by Richard Scrushy in 1984 as a provider of outpatient sports medicine, HealthSouth went public in 1986 with twelve outpatient facilities. From 1991 to 1996 HealthSouth’s growth rivaled that of Columbia/HCA, with revenues rising from $278 million in 1991 to $2.436 billion in 1996—a 776 percent increase.\textsuperscript{17}

By the end of 1997 HealthSouth operated 104 freestanding rehabilitation hospitals across the United States, 54 percent of the total number of rehabilitation hospitals nationwide. A series of large-scale HealthSouth acquisitions from 1993 to 1997 greatly reduced the number of major rehabilitation competitors. In the early 1990s the dominant providers of inpatient rehabilitation included HealthSouth, Continental Medical Systems (CMS), National Medical Enterprises (NME), ReLife, NovaCare, and AdvantageHealth. Today HealthSouth has assimilated virtually all of its former competitors in the inpatient market (Exhibit 1).\textsuperscript{18}

The financial strategy pursued by HealthSouth has been to position itself for a rapidly changing payment environment. Whereas most of its competitors had focused primarily on revenues from the Medicare program, HealthSouth focused on what it considered to be a more profitable revenue source: managed care plans.\textsuperscript{19} As the stocks of HealthSouth’s competitors came under increasing pressure as a result of earnings shortfalls, HealthSouth was in a position to acquire these companies relatively cheaply. While amassing by far the largest share of rehabilitation capacity in the United States, HealthSouth has consistently increased its profitability.\textsuperscript{20}

In some respects, however, HealthSouth’s overall strategy appears to be out of sync with major industry and market trends. First, as previously mentioned, HealthSouth continues to invest heavily in freestanding rehabilitation hospitals at a time when demand for hospital-based rehabilitation is slackening because of managed care. Other rehabilitation companies have been eager to jettison the hospital portion of their portfolios, as NovaCare did when it sold its eleven hospitals to HealthSouth in 1995. Second, HealthSouth appears to have limited subacute capacity at a time when subacute care has become the fastest-growing segment of the rehabilitation industry. And third, HealthSouth’s four-part inte-
grated service model strategy in each market has some inherent limitations. HealthSouth expects to achieve important cross-referrals from its portfolio of outpatient diagnostic centers, outpatient surgery centers, outpatient rehabilitation centers, and rehabilitation hospitals. However, most patients coming to rehabilitation hospitals are referred from acute care hospitals, not outpatient surgery centers.

**Implications For Consumers**

The emergence of large, for-profit multimarket chains is still viewed with some trepidation by many consumers and consumer advocates. For policy analysts and regulators, questions remain: What will be the effect of these changes on consumers, and are these developments in the public interest?

Brand-name recognition is a relatively new phenomenon in health care, although fairly typical in other industries. Other chains such as office-supply retailers have become dominant nationally in their industries because they can provide a wider selection of products at lower prices than most local suppliers can. The same pattern is holding true in the rehabilitation industry. The for-profit rehabilitation provider chains are becoming the cost leaders. According to one investment firm, HealthSouth “is flattening the competition, which is having increasing difficulty competing with its low-cost position, financial strength, quality outcomes and industry stature.”

Small locally based providers obviously do not have access to the type of capital resources that HealthSouth enjoys, and they cannot replicate many of these capabilities. As the national chains continue to swallow smaller local providers, the number of options available to consumers is decreasing. Nevertheless, HealthSouth’s literature acknowledges the importance of community commitment, and local HealthSouth administrators maintain that they have much autonomy in their decision making. Local autonomy, however, has its limits in a system that seeks to establish standardized protocols, present a uniform national image, and centralize many
There is insufficient evidence to evaluate whether the overall effect on consumers of the rapid growth of for-profit hospital chains in the medical rehabilitation industry has been positive or negative. Consolidation in the ownership of rehabilitation facilities has not produced widespread facility closures, and therefore access has not been recognizably eroded. The cost of inpatient rehabilitation is reportedly being driven down. Nevertheless, consolidation is continuing at a rapid pace, and despite the relatively low barriers to entry in the inpatient medical rehabilitation business, excessive market concentration remains a concern.

**Public Policy Response**

The Federal Trade Commission (FTC) continues to track these developments. In 1995 the FTC delayed the final approval of HealthSouth’s planned $180 million acquisition of ReLife, Inc., on the grounds that the move would substantially lessen the competition for inpatient rehabilitation services in three geographic markets. The consent agreement subsequently established by the FTC required HealthSouth to divest three facilities and to obtain FTC approval before attempting to engage in any subsequent mergers within those three geographic areas.

HealthSouth’s rapid growth in recent years has some observers concerned about its potential market domination. Should consolidation proceed too far, some fear, consumer access and choice may become limited and costs may increase. In the coming years, the FTC and other government regulators will have to assess these concerns and determine whether adequate competition exists. For now, however, consolidation continues largely unabated.

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**Notes**

2. For example, persons who incur high-level spinal cord injuries are now much more likely to survive the trauma than they were at any time in the past. This reduction in mortality has corresponded with an increase in functional disability. For further discussion, see Institute of Medicine, *Disability in America* (Washington: National Academy Press, 1991).
3. This proportion increased during the 1980s, largely because of the exclusion of rehabilitation services from Medicare’s prospective payment system. In 1986 Medicare paid for 57 percent of days spent in rehabilitation hospitals. See S. Wolk and T. Blair, *Trends in Medical Rehabilitation* (Reston, Va.: American Rehabilitation Association, 1994).
4. Ibid.


17. Ibid.

18. NovaCare sold its rehabilitation hospital division to HealthSouth in 1995 but continues to be a major competitor in the outpatient sector.

19. In 1993 HealthSouth’s payer mix was only 30.6 percent Medicare. By contrast, the companies acquired by HealthSouth relied much more heavily on Medicare revenues. At the time of the acquisitions, the former National Medical Enterprises hospitals derived 77 percent of their revenues from Medicare; ReLife, 81 percent; and NovaCare, 77 percent. These figures are cited by J. Swenson and A. Bennett in “HealthSouth Corporation: The Premier Provider of Rehabilitation and Outpatient Surgical Services” (Investment analyst report, Alex. Brown and Sons, Baltimore, 1 December 1995).

20. In part, this has been achieved by having representatives of acquired facilities attend what is called the “HealthSouth University,” where “everyone receives a thorough indoctrination into the HealthSouth culture of pulling the wagon” (italics theirs). *HealthSouth Corporation 1996 Annual Report*.


22. Based on authors’ conversations with local HealthSouth administrators.

23. Hicks et al., “HealthSouth.”