The Blue Ridge Academic Health Group

The Academic Health Center: Delivery System Design in the Changing Health Care Ecosystem*—Sizing the Clinical Enterprise to Support the Academic Mission*

SPRING 2017 ✦ REPORT 21

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(July 2016 meeting)

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This book is dedicated to the memory of Mark Richardson, MD, who passed away in 2016 following an accident. He was a member of the Blue Ridge Academic Health Group since 2012.

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Introduction

The Blue Ridge Academic Health Group devoted its 2016 report[1] to a consideration of how academic health centers (AHCs) should size their delivery systems to support their educational mission. Findings included the key observation that AHCs need to determine how they will secure access to sufficient numbers of patients through growth, acquisition, and partnerships to produce the volume of specialty referrals required to support tertiary and quaternary care teaching hospitals, and to meet the training needs of residency and fellowship programs. In its 2015 report, the Blue Ridge Group explored how AHCs support their vital research mission.[2] What has become apparent is that current risks to each of the missions are substantial but that planning to address them, in a proactive fashion, can enable AHCs to sustain continued success. At the same time, "business as usual" will not suffice.

Understanding the benefits and risks of partnerships, affiliations, or joint ventures from the perspective of their prospective partners must become a priority for AHCs if they are to be viewed as successful and attractive collaborators.

At its most recent meeting, the Blue Ridge Group extended that discussion to assessing the approaches that AHCs are using to build the clinical delivery system needed to support their academic mission. Case studies from AHCs serving different geographic regions of the country illustrated in compelling detail how AHC leaders are assessing a broad spectrum of possible moves, including expansion of hospital and clinic capacity, investigation of mergers or acquisitions, partnerships with community health systems and with other AHCs, and extending clinical networks. In a few cases, AHCs have split legally from their parent universities to enable the AHC to continue expanding and financing its operations and capital needs while creating governance structures to better address the unique policy, management, and strategic needs of both entities. Three key conclusions include the following:

- Few AHCs can afford the luxury of doing nothing to secure the market presence and patient base needed to successfully fulfill their mission.
- Partnering with other health care entities, as opposed to building or buying new facilities, is often the preferred solution for AHCs, even those few AHCs with large cash reserves. This is true for strategic as well as legal and financial reasons.
- Governing boards and AHC leaders will have to fashion their own individual solutions based on their local environments and the opportunities and restraints inherent to their individual missions and operating structures.

A recurring theme was that understanding the benefits and risks of partnerships, affiliations, or joint ventures from the perspective of their prospective partners must become a priority for AHCs if they are to be viewed as successful and attractive collaborators. While some community health systems considering partnership with an AHC may initially feel threatened by the prospect of engaging with a large academic health system, AHCs have significant advantages and benefits to offer these partners. They include providing a pipeline of physicians and other health care professionals to partner health care systems; access to clinical trials and research; access to expertise for complex and rare disease management; and, though often not recognized or appropriately valued by AHCs and their parent universities and governing boards, the demonstrable worth of academic brands.*

*What is sometimes called the "halo effect" around a university's brand does have economic and social value. Its exact dimensions are imprecise, but there is sufficient evidence for such an effect that AHCs should clearly recognize and include this variable in their calculations and negotiations. Its relative value from region to region deserves to be studied.

I. Imperatives for Redesign and Regrowth

Past Blue Ridge reports have frequently noted that AHCs in the United States face competitive forces that impact upon all parts of their missions—education, research, health care delivery, and public service. Today, the dominant forces they face are rapid consolidations in the health care marketplace and the increasing scale of other players in the sector. Hospital mergers and acquisitions have increased sharply from 2007 to 2015, with the magnitude of the institutions acquired possessing revenues nearing $25 billion in 2015 (Chartis Group). Fewer and larger payers and providers are seeking economies of scale and competitive advantage against a backdrop of slowing revenues and increasing marketplace pressure. AHCs that were the largest players when the community was dominated by freestanding hospitals and independent physicians are increasingly concerned about being eclipsed by larger integrated delivery systems that attempt to retain patients within their own health systems. While demand for AHC faculty and hospital services remains strong in most communities, some AHCs are faced with growing concern about their ability to continue dependably generating operating margins sufficient to cross-subsidize their education and research missions, as well as, frequently, their parent universities.

Tables 1-3 (compiled by Chartis Group, 2016, from publicly available reports) compare net revenues of select leading payers, non-academic health care systems, and academic health systems. The substantial differences of scale between the largest payers and the largest health care systems, on the one hand, and even the largest academic health care systems, on the other, are evident. (It should also be noted that merger activity continues apace, with, for example, Catholic Heath Initiatives and Dignity Health announcing a nonbinding agreement in late October to pursue an "alignment" that would create the nation's second-largest not-for-profit health system, trailing only Kaiser Permanente.)[3]

In the face of these competitive pressures and the geographic expansion of many large regional and national health systems, AHCs must secure access to a sufficient part of their referral stream to ensure that they can maintain positive margin; teach students, residents, fellows, and others; do research; utilize their hospitals and clinics; and meet their evolving system goals of improving population health. Experience suggests that many AHCs are doing so successfully. In some cases, workable approaches involve acquiring new facilities, merging outright with community hospitals or smaller health systems, and/or purchasing physician practices. But often, securing continued access to patients through various forms of partnership, rather than ownership, accomplishes the same end, with lower sunk costs and greater compensating strategic advantages. In addition to financial considerations, cultural differences between AHCs and community hospitals, physician groups, or other health systems can loom large on both sides, requiring care, sensitivity, and careful approaches by both academic health leaders and the leadership of potential partner organizations. If handled clumsily, these differences could impact negatively on critical AHC missions.

Many AHCs are finding that growth is needed to meet their educational needs. As explained in the 2016 Blue Ridge report, and illustrated with multiple case studies, dependably accessing enough complex quaternary cases to provide trainees with needed experience in areas such as neurosurgery or transplant often requires the AHC to access 3 to 6 million covered lives.

In this current analysis, we conclude that similar considerations apply to questions of scaling the clinical enterprise so that the entire academic mission can be met. Most research-intensive AHCs need access to a referral base of at least 3 million lives or more to maintain their clinical delivery systems and serve their traditional core academic missions of education and research. AHCs have traditionally excelled at providing high-acuity care. A "continuum of care" across many venues and the systems to provide clinical information across this continuum are required for population health. This is new territory for most AHCs. Addressing the population health consideration in AHCs is critical if future health professionals are to be prepared for their emerging careers once they leave the AHCs and if research is to address

In the face of competitive pressures and the geographic expansion of many large regional and national health systems, AHCs must secure access to a sufficient part of their referral stream to ensure that they can maintain positive margin; teach students, residents, fellows, and others; utilize their hospitals and clinics; and meet their evolving system goals of improving population health.

Table 1. **Leading Payers (by net revenues)**

Payer	Net Revenues, 2015 ($billions)
UnitedHealthcare	$157
Anthem	$79
Aetna	$60
Humana	$54
Cigna	$38
Health Care Service Corporation	$35

Source: Audited financial statements and annual reports. Credit: The Chartis Group, LLC. © 2016

Table 2. **Illustrative Academic Health Centers**

Health System	Net Revenues, 2015 ($billions)
University of Pittsburgh Medical Center	$12.0
Partners HealthCare	11.7
Mayo Clinic	10.3
Northwell Health (formerly North Shore-LIJ)	8.7
Cleveland Clinic Health System	7.2
Johns Hopkins Health System[a]	7.0
Banner Health/University of Arizona	7.0
Indiana University Health	6.1
University of Pennsylvania[b]	5.4
New York-Presbyterian[c]	5.3
Mount Sinai Health System	4.2
Duke University Health System[d]	4.0
Northwestern Memorial HealthCare	3.9
Yale New Haven Health	3.6

a. Johns Hopkins excludes the School of Medicine. Total includes an estimated $1.5 billion for revenue from joint venture health plans and $5.5 billion of JHHS revenues.
b. University of Pennsylvania includes Lancacster General Hospital (acquired August 2015).
c. New York Presbyterian (NYP) excludes Columbia and Cornell practice plans. Total includes NYP-Queens (NYP became the active parent in July 2015).
d. Total includes an estimated $1 billion for revenue from faculty practice.

Source: Audited financial statements and annual reports. Credit: The Chartis Group, LLC. © 2016

Table 3. **Illustrative Regional and Multi-State Health Systems**

Health System	Net Revenues, 2015 (billions)
Kaiser Permanente	$60.7
HCA Healthcare	$39.7
Ascension Health	$20.5
Community Health Systems	$19.4
Tenet Healthcare	$18.6
Catholic Health Initiatives	$15.2
Trinity Health	14.3
InterMountain Health Care	6.1
Advocate Health	5.4
Sentara Healthcare	4.8
Geisinger Health System	4.6
Texas Health Resources	4.3
Novant Health	4.1

Source: Audited financial statements and annual reports. Credit: The Chartis Group, LLC. © 2016

the full spectrum of health studies.

As **figure 1** depicts, there are compelling reasons why AHCs are often finding that they need to build scale, including:

- Supporting the infrastructure investments needed to succeed at population health
- Maintaining their position as market leaders

This report focuses on additional reasons, specifically those related to the academic mission, including:

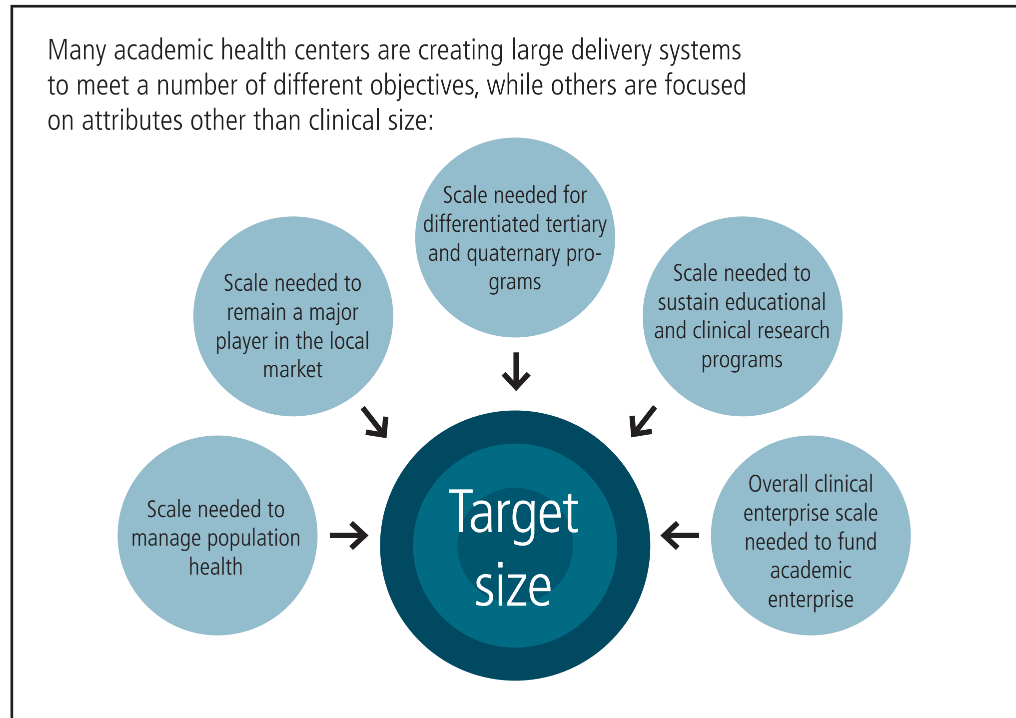
- Maintaining sufficient cases for training programs
- Sustaining the scope of patients needed for educational and clinical research programs
- In many cases, maintaining sufficient revenue and market presence to support the cross-subsidy or academic transfer funds required to fund academic programs, whether in medicine and associated health professional schools, parent universities, or both.

While the importance of any one reason varies from place to place, virtually all factors are cogent to some extent.

The dynamic nature of today's competitive scene plus emerging grand challenges of precision medicine and personalized care illustrate that complacency is simply not sound decision-making. Every AHC, to survive, much less to improve and thrive, needs to adopt the goal of becoming a learning organization as described in the National Academy of Medicine initiative known as The Learning Health System—one "in which science, informatics, incentives, and culture are aligned for continuous improvement and innovation, with best practices seamlessly embedded in the delivery process and new knowledge captured as an integral by-product of the delivery experience."[4]

As discussed in a series of previous Blue Ridge reports,[2,5] AHCs play a unique role in the American health care ecosystem. In addition to their value as essential educational and research organizations, and partly by virtue of their geographic locations and historical circumstances, they tend to be among the most prominent (and sometimes

Figure 1. **New Scale Requirements**



Source: The Chartis Group, LLC. © 2016

the predominant) not-for-profit providers in their home markets. They also tend to have an outsized presence in providing tertiary and quaternary care in their regions, a comprehensive array of specialty and subspecialty expertise, a disproportionately vital role in caring for the indigent, and the historic missions of fueling medical innovation through biomedical research and training the next generation of providers.

Currently, AHCs are experiencing disruption in a domain that has generally been their own, e.g., entry-level medical education. While local or regional competition in clinical care is nothing new, a growing number of AHCs are challenged by new combinations of providers in local or regional markets. Even an activity as intrinsic and uniquely identified with universities as entry-level medical education is attracting new players. In December 2015, Kaiser Permanente, the country's largest health system by net revenue (see table 3), announced plans to open its own medical school in a location later identified as Pasadena, California.

Kaiser spoke of its intention to redesign medical education with more emphasis on cultural diversity, shared decision-making between doctors and patients, practice in non-traditional settings, and "collaboration and teamwork."[6] The first class will begin in 2019, as part of what *The Wall Street Journal* called "a broader effort to change traditional medical education. . .while new medical schools are cropping up and aiming to fill what has been projected as a major physician shortage in future years."[7]

One concern about the new enterprise is whether the goals enunciated by Kaiser may deemphasize some current goals of medical educators. Medical education has evolved significantly in the past decade and all the goals stated by Kaiser are now a significant component in modern medical education. But they are not the sole focus. Most medical educators feel that it is also of critical importance that tomorrow's physicians develop a strong, broad foundation of bioscience and medical information, lifelong learning skills that will be necessary in the future, a sophisticated knowledge of web-based education and clinical care, and, importantly, the skills to evaluate the therapeutic efficacy and cost/benefit ratio of innovative new technologies. It might be attractive to a proprietary medical school not to include these components in the curriculum, accomplishing short-term goals but failing to achieve long-term, sustained improvement in health.

Other examples of health systems becoming the prime movers in establishing new partnerships with universities include Banner Health (acquiring the hospital and faculty practice plan of the University of Arizona),[8] Hackensack-Meridian (opening a new medical school with Seton Hall University),[9] Beaumont Health (opened a new medical school with Oakland University),[10] Northwell (opening a new medical school with Hofstra University), and Carilion Clinic's new medical school in partnership with Virginia Tech.[11] In another model, Geisinger Health System announced in September 2016 that it intends to buy an independent medical school, the Commonwealth Medical College, with a goal of meeting its need for physicians in its local service areas.[12] Since 2010, 18 new medical or osteopathic schools have been accredited, many in partnership with a health system. The Chartis Group has identified another 36 allopathic medical schools that are under development and/or awaiting accreditation.

In addition to these examples of the proliferation of allopathic medical schools, there have also been increases in the number of U.S. osteopathic schools. The result is an increasing number of medical and osteopathic students competing for a relatively fixed number of graduate medical education positions.

Perhaps the most seismic recent transformation is in the financial underpinning of academic medicine, as predictable clinical reimbursement models for both hospital and physicians shift to much less predictability with pay-for-value and a variety of population risk models. Discussed at length in several previous Blue Ridge reports[1,5] and supported by the Blue Ridge Group as good for health and health care, this multi-year shift will begin to transfer responsibility for the costs and outcomes of care for defined patient populations from payers to providers. More efficient, effective, and proactive care, it is argued, will save money in clinical costs and begin to bend the cost curve for the $3 trillion health care sector overall. Spirited discussion continues as to whether this new model of care is truly population health (in which AHCs and other health care systems might take responsibility for the health outcomes of defined geographic communities or regions), or a watered-down version, in which providers are assuming responsibility only for "attributed lives."[13] Whether under a strong or weak approach to population health, this emerging model of care responsibility increases financial uncertainty as well as new opportunities and risks in strategic planning for AHCs.

A recent vivid illustration of the challenges ahead was provided by Dartmouth-Hitchcock Medical Center. Faculty there helped develop the initial proposal that grew into the concept of accountable care organizations (ACOs).[14] In September 2016, Dartmouth announced it was withdrawing from its agreement to run an ACO, saying it was losing too much money. In an interview with *The New York Times,* Dartmouth officials said they had been able to cut costs, but not enough to avoid paying a penalty. They observed that it is harder for health systems that are already running efficiently to cut costs as much as organizations that are too costly to begin with.[15] With the Congressional Budget Office still planning to achieve savings of $34 billion over the next decade through programs launched by the Center for Medicare and Medicaid Innovation, the spirit of innovation remains alive, albeit unsettled. Determining just how "lean" or "fat" AHCs are today is both art and science. Clearly, a learning care system is interested in learning how to be safe, efficient, effective, timely, patient centered, and equitable as well as paying due attention to population health as reflected in all the dimensions of the social determinants of health.

II. Multiple Approaches to Responding

As noted earlier, many research-intensive AHCs find that they need dependable access to a referral network of 3 million or more lives to support training requirements for subspecialty residencies. A similar calculus seems to apply to the overall size requirements for research-intensive AHCs to satisfy all other elements of their mission—including clinical delivery, research, and public and community service. Referral networks that are on the scale of small states, or significant por-

Table 4. **AHCs Have a Range of Models to Reach Necessary Size and Scale**

Model	Comments	Examples
Building and owning	AHCs have total control, capital intensive; strong potential upside but for most will be limited by capital availability and CON restrictions in some states	Emory Healthcare: Emory Johns Creek Hospital
Acquisition	Less capital-intensive, can create win-wins for community entities who get access to staffing and electronic health records as well as for AHCs who create placement opportunities for graduates and access to referrals	University of Michigan affiliation with Metro Health in Grand Rapids
Mergers of AHCs with non-academic health systems	More popular in 1990s than currently; can be successful but raises many issues of differences in mission, governance, leadership style, cultural fit, operations, and brand, which must be negotiated. Promised savings and efficiencies have often proved elusive in practice. Many of these relationships have dissolved because of the aforementioned issues.	Recent mergers are being contested by the FTC. Penn State Hershey Medical Center and PinnacleHealth System abandoned their efforts in December 2016 after objection by the FTC. The proposed Advocate Health Care and NorthShore University Health System merger in the Chicago region are currently going to trial. (See Section VII: Legal Issues and Considerations.)
Formal joint ventures and contractual partnerships	Being pursued by many AHCs looking for bi-directional win-wins with community entities (hospitals, clinics, physician groups). AHCs can often extend attractive benefits to partners in the form of brand, recruitment, and clinical program development, quality improvement, electronic health records, and other business practices while securing access to complex referrals and new teaching sites needed for clinical and educational programs.	University of Chicago Medicine Cancer Center joint venture with Silver Cross Hospital University of MIchigan relationship with MidMichigan Health System
Affiliation agreements	Less capital-intensive, allows each party to define their specific goals for specific affiliated programs. These are contractual agreements. Therefore, care must be taken to define specific mission goals, financial and performance terms, and length of time of the agreement. These tend to be easier to construct, often require dedicated relationship management, and can often be easily terminated, particularly if the affiliate eventually needs a capital partner. These relationships can be a bridge to a more integrated model. In general, there is less permanence in these agreements, especially if one entity becomes part of another competing entity.	University of Michigan contractual agreements to provide clinical services at Trinity and Ascension hospitals as well as at other affiliates throughout Michigan.

Table 4. **AHCs Have a Range of Models to Reach Necessary Size and Scale** (continued)

Model	Comments	Examples
Physician referral networks/clinically integrated networks	Highly popular and effective way for AHCs to maintain and build relationships with physicians in a broad region; can help maintain and enhance access to referrals with limited capital investment. Physician groups get access to population health infrastructure and value-based contracts and the AHC brand in some cases.	Vanderbilt University Medical Center University of Chicago Medicine University of Michigan Health System relationship with Physicians Organization of Michigan ACO and Together Health Emory Healthcare Network University of Rochester Accountable Health Partners

tions of larger states, are increasingly required, and the largest AHC networks are beginning to span multi-state regions (see, for instance, the case studies on BJC HealthCare and Vanderbilt University Medical Center in this report).

A wide range of approaches will be required by most AHCs to secure this scale (see **table 4** for examples). They include such capital-intensive options as expanding ambulatory and inpatient facilities to serve additional patients or buying and owning other existing hospitals, clinics, or networks. While these strategies maintain maximum control for an AHC, they also entail significant financial and operational risk and frequently are not affordable in the near term, because of insufficient cash reserves or an inability to access sufficient bond financing. As seen in the case studies in this report, many AHCs, even some of the largest and most well capitalized, find it advantageous to pursue a wide range of other arrangements, searching for win-win partnerships to which each party brings distinctive assets needed by the other.

All options that exist in the marketplace have advantages and disadvantages. Outright acquisitions and mergers provide more control but also more financial risk. Looser agreements, joint operating agreements (JOAs), contractual arrangements, and affiliations pose less financial risk to AHCs, but the diminished control requires a great deal of "relationship management," which in itself is time-consuming for leadership and is more easily disrupted if a partner is acquired by a competitor. Simply put, the predominant model for the past 15 years of acquiring hospitals, health centers, and physician groups is a model that is more affordable for large insurance companies and very large for-profit health systems but increasingly not for AHCs. Additionally, this strategy has proven to be effective in some but not all such endeavors—leading to the conclusion that a more broad and balanced approach to network expansion will be necessary for most AHCs.

Partnership approaches include but are not limited to the following:

- Regional and statewide physician network development, either by employing physicians directly or partnering with community providers
- Development of clinically integrated networks (CINs) to manage the health of defined populations and to pursue value-based payment models
- Joint ventures for:
  - Specific service lines, such as maternal and child health, cancer programs, and others;
  - New facilities, such as ambulatory surgery centers, rehab hospitals, and other services
  - Insurance offerings among providers and between AHCs and insurers.
- JOAs to integrate the economics of specific assets or programs (an approach that is typically used to avoid the challenges of merging public and private assets)
- Extension of the AHC's academic programs to community providers

- Sharing of best practices and protocols to improve value
- Integration of information technology (IT) and administrative infrastructure to improve efficiency and effectiveness.

III. How to Choose Among and Pursue the Right Opportunities

In the rapidly changing health care sector, which represents more than one-seventh of the nation's GDP, leaders of AHCs need a clear roadmap and action plan. Sitting still is seldom a winning strategy, as the market at large consolidates rapidly around AHCs. One recent case study (anonymous) presented to the Blue Ridge Group at its 2016 meeting depicted an academic medical center (AMC) that had lost its once-predominant market position in just a matter of a few years, as both for-profit and not-for-profit competitors made acquisitions rapidly, surpassing the AMC in terms of the number of imputed covered lives in their referral networks.

An AAMC advisory panel composed largely of AHC CEOs found, in its 2014 report *Advancing the Academic Health System for the Future*, that "most AHCs today are simply not at the scale of operations required to be strategically and operationally successful in the years ahead; and that they will need to be several orders of magnitude larger in order to do so or will need to rethink their operating model and their operations strategy."[16] In health care markets that are rapidly consolidating around AHCs, the AAMC advisory panel posited four principal options for AHCs:

- Form a system
- Partner with others in collaborative networks
- Merge into a system
- "Shrink in isolation"

A useful thought experiment for every AHC leadership team and board might be to ask, What will your situation look like in 20 years if you do nothing now? How about in five years?

Making the right decisions requires consideration of educational, research, clinical, and financial needs and resources as well as a careful appraisal of the competitive environment in which unattached players—stand-alone hospitals, clinics, health systems, physician groups, and private practices—are rapidly finding interested suitors. All of this, of course, must be framed continually in the AHC's distinctive commitments to a mission of education, research, clinical care, and community service.

While mergers are increasing in the health care industry at large, their track record is mixed in the realm of teaching hospitals (see **table 5**). In a 2014 *Academic Medicine* study, Thier and colleagues noted that the 1990s represented a high-water mark for successful mergers of teaching hospitals.[17] Three success stories that have stood the test of time were the acquisition of Presbyterian Hospital and Pennsylvania Hospital by the University of Pennsylvania Health System, the merger of the Harvard-affiliated Massachusetts General Hospital and Brigham and Women's Hospital to create Partners HealthCare, and the merger of Cornell-affiliated New York Hospital and Columbia-affiliated Presbyterian Hospital to create New York-Presbyterian Hospital. (Other attempted combinations, around the same time, were failures, including those of the Stanford and University of California-San Francisco medical centers, and New York University and Mount Sinai hospitals and medical schools. Factors cited as contributing to these very public failures included lack of faculty support, cultural differences, failure to achieve desired efficiencies and savings through integration, and geographic distance between the two institutions.)[18-22]

This report and the case studies presented here are largely about the decision-making and experiences of leading AHCs that are following a different path—partnering (rather than pursuing formal mergers or acquisitions) with others—while capitalizing on positions of strength that they are able to translate into win-win benefits for themselves and the other entities with whom they are partnering.

Assessment of needs and benefits

AHC leaders must "play the hand they're dealt"—which means being honest with themselves about what their actual strengths and weaknesses are as they set out to bring in new partners and compete with larger and possibly better-capitalized competitors for contracts and patients. AHCs must meet multiple objectives that correspond to their multiple goals—academic (teaching and research), financial, and social. In the case of public AHCs, they must succeed as well in a political environment where they may sometimes be the subjects of partisan debate over questions of access, cost, and prestige—magnifying the pressures on leadership. Political pressures may well be felt by large private AHCs as well, which are often among the largest employers and most critical economic engines in their local communities.

In *Advancing the Academic Health System for the Future*, the advisory panel of AHC leaders referred to earlier provided a formidable–but helpful—checklist of factors that AHC leaders should work their way through prior to seeking expansion through new partnerships. They advised rigorous self-scrutiny in the following categories:

- leadership and culture
- cost management and quality of care
- transparency of information, both within and without, with regard to costs, pricing, and quality of care
- access to capital and the strength of balance sheets
- ability to provide primary care, where strong networks are essential as pre-positioning for the successful practice of population health
- data analytics
- having the operations capacity to successfully manage financial risk associated with vehicles such as HMOs and capitation that are needed in a population health world
- being able to achieve greater scale
- sharpening the institution's brand and value proposition
- practicing ongoing innovation with respect to care delivery

Table 5. **Academic Health Mergers—Successes and Failures**

Failed Mergers	Reasons for Failure
New York University and Mount Sinai (Mount Sinai NYU Health), two consecutive attempts	Loss of trust, lack of early wins, cultural differences, faculty opposition, poor communication, divided senior leadership[18-20]
University of California-San Francisco and Stanford	Differences between patient bases and faculty practice plans, financial losses, geographic distance between partners[21]
Penn State and Geisinger	Financial losses, cultural differences, failure to realize cost efficiencies[20, 23]

Successful Mergers	Reasons for Success
University of Pennsylvania Health System, Presbyterian Hospital, and Pennsylvania Hospital Massachusetts General Hospital and Brigham and Women's Hospital (Partners HealthCare) New York Hospital - Presbyterian Hospital	Commonalities: ■ Leadership and trust (senior executives aligned, trustees supportive) ■ Managing uncertainty (clear strategy and communications, transparent process) ■ Medical staff stable and engaged ■ Cultural gaps bridged, clinical integration paced organically[17]

- exercising policy leadership both locally and on a statewide basis.[16]

Factors for leadership to consider

In accord with the two most recent Blue Ridge reports,[1, 2] we would add that any AHC's checklist should also include assessing the impact of health system changes on its other primary missions—those of research, education, and community service—for all must be considered as a totality in the unique enterprise of academic health.

Fortunately for AHCs, the experience of many leaders who pursue expansion shows that their institutions bring many attractive assets to potential partners at community hospitals and clinics. The brands of academic health centers, though difficult to quantify in value, are frequently among the most powerful in their respective states. They benefit from association with universities that have generations of alumni and powerful academic reputations. This is an attractive halo to extend to prospective partners, with appropriate caveats and qualifications governing usage. One of the meeting participants indicated that their AHC had conducted several brand studies jointly funded by potential partner health systems; these studies documented the increased preference consumers perceived from attaching the AHC's brand to the community health system's name. In each case, the increased consumer awareness and preference were significant. On a more practical level, some community hospitals lack the resources necessary to implement the full range of business systems available to AHCs, including IT improvements, electronic health record implementations that connect with a larger system, group purchasing savings, and other related offerings. Finally, the possibility of medical staffing through the AHC, possibly using residents as well as faculty, is attractive to many hospitals and clinics in smaller, rural, and underserved markets.

Partnerships must be based on a principle of bi-directionality—making sure that benefits, as well as risks and costs, are shared by both sides of the partnership.

Against this must be placed issues of the merging of cultures, especially the skepticism or defensiveness that many community hospitals and practicing physicians may feel as they consider partnering with a much larger AHC. Much anecdotal evidence exists documenting potential partners' fears of being controlled by academically oriented interests and institutions that may use them to "balance the budget in the history department," as one AHC leader put it. Anticipating such objections and examining the flow of funds within the AHC to ensure that both partners' requirements are properly served from new relationships is time well spent. Partnerships must be based on a principle of bi-directionality—making sure that benefits, as well as risks and costs, are shared by both sides of the partnership. As individual AHCs explore their options, it is imperative to start with a clear understanding of the financial interdependencies of the quadripartite missions (research, education, patient care, and community service) within the AHC. The impact on the university, school of medicine and other health professional schools, hospital, and physician practice, must all be assessed. Without this understanding, it is difficult to define what the AHC requires from a relationship, an essential step before the AHC offers to extend its brand.

Forming a strategic review committee or task force to do a rigorous self-assessment and delineate strategic opportunities and threats is an obligatory step as the AHC evaluates its options. The strategic process needs to be well directed, with appropriate selection of members drawn from governance, leadership, and key constituencies. Despite the large size that such planning bodies can reach over time as one constituency after another is recognized with inclusion, it is wise to also reach out to one or more external experts, independent from the institution. Outside leaders can provide a clear-eyed perspective that may be missed by institutional insiders. A balanced membership that is appropriately inclusive and that respects the confidentiality of the sensitive nature of the discussions is required. Not infrequently, key constituencies from participants can scuttle a deal if information is not appropriately handled.

A historical review of successful mergers and partnerships can be instructive, while keeping in mind that mission responsibilities, local marketing conditions and cultures, and timing vis-à-vis evolution of medical payment and delivery systems will require tailoring of strategies for each AHC and its potential partners. The strategies and required institutional commitments can vary dramatically from case to case. As described in a case study presented at the 2016 Blue Ridge Group meeting, BJC HealthCare, in St. Louis, has built a multi-state, eight-member collaborative, achieving cost savings of $147 million on an initial investment of $500,000 for BJC alone, and savings of $215 million for all eight collaborative systems on an investment of $2.4 million.

For another example, a case study presented by University of Kentucky leadership in a 2014 *Academic Medicine* article described a multi-year venture in transforming their AHC into the core of a regional referral center.[24] Beginning in 2001, UK began strategic planning that resulted in a recognition that UK needed to invest $800 million over the course of a decade to improve its facilities, retain clinical faculty, and compete successfully in the local and regional health care markets.[24] Along with facilities improvements, strategic planning identified three principal needs: (1) to focus on specialty "destination" areas such as Level 1 trauma and transplant, (2) to develop "mutually beneficial" relationships with community providers, and (3) to concentrate on improving safety, efficiency, quality, and patient satisfaction. In support of university strategic planning that began in 2001, UK identified the need to rebrand itself as UK HealthCare and to widen its sights from its historic base in eastern Kentucky, representing a market of about 2 million people, into a regional market of 7.5 million people, covering all of Kentucky, the western portion of West Virginia, southern Ohio, and eastern Tennessee. Rejecting the formation of ACOs as too costly and potentially too risky for AHCs such as themselves, UK HealthCare chose instead to expand through partnerships with payers and other providers—initially small rural providers and then with larger hospitals. These hospitals serve as "subregional hubs," aggregating the low-incidence, complex cases that must be referred to UK for subspecialty care. The initial estimated need of $800 million has turned into a total projected price tag of $2.4 billion dollars by 2020, including all investments in faculties, recruitment, programs, and equipment needed to meet UK's goal of becoming a major regional referral center. "Whatever goals AMCs set for themselves, they should have a clear understanding of the financial resources required to reach them," UK's leaders observe.

Without question, financial capacity is a fundamental constraint—but the good news is that there are many paths to success, depending on the objectives and partnership opportunities. Partnerships (as opposed to growth or merger and acquisition strategies) may allow relatively modest amounts of capital (albeit often with significant institutional time and effort) to achieve a good outcome.

It is important to maintain access to sufficient capital to accomplish the multiple missions of AHCs. In that context, perhaps surprisingly in light of recent worries about the financial health of teaching hospitals, experience shows many, if not most, AHC hospitals are running near full patient capacity. Revenue growth is also robust, around the 5% range, as illustrated by a 2015 Moody's study of the not-for-profit hospital sector.[25] While any business experiencing steady 5% revenue growth might seem robust in the current environment, AHC leaders also point out that expense increases, driven largely by the costs of pharmaceuticals and medical equipment, continue to grow at similar rates. In 2014, Moody's reported, median revenue growth was 4.7%, while median expense growth was 4.6%. Still, multi-year trends are favorable. Especially in comparison with the experience of many community hospitals and clinics, this is one way in which AHCs are playing from a desirable position as they come offering partnerships or affiliations.

AHC leaders must be mindful of the need to diversify their sources of revenue and distribute risk. Clinical revenues are increasing, but as we have noted in previous reports (e.g. in 2014[5]), academic medicine must cultivate other critical sources of revenue, including grants for sponsored research, tuitions, and perhaps more than anything else, substantial amounts of philanthropy, rooted in the experience of grateful patients who have grappled with challenging illnesses treated most effectively by AHC physicians. In addition, state support (although in many cases, a small and decreas-

ing source of funding) still plays a significant role for many (especially public) AHCs. These diverse sources of revenue are usually not accessible in the same measure to community hospitals, clinics, and physician groups.

Academic standing and governance issues
A subject under constant discussion is the relationship of AHCs with their parent or affiliated universities—and in particular, assessment of and response to the attitudes of presidents and trustees toward their associated AHCs. For many, the academic health enterprise remains, in magnitude, a university's greatest single risk exposure—and a risk that will likely deepen as AHCs move into the practice of population health. However, AHCs also remain jewels in the crown, as a recent Moody's report on the relationship of universities and AHCs emphasized.[26] There is a deep symbiotic relationship between universities and AHCs. Even when they represent two separate organizations, such as at Johns Hopkins or Northwestern, or when they separate formally for clinical delivery purposes (see the Vanderbilt case study in this report), they continue to be linked by name, brand, alumni, faculty, and educational and research missions. And increasingly, there is a growing recognition by university presidents and boards of the unique and indispensable role that AHCs play—not only in our health care system, but in our society.

University-based business schools do not incorporate themselves and turn into actual businesses, with capital at risk in the markets; university-based law schools do not hang out their shingles and engage in corporate litigation, competing with private law firms. Uniquely, though, most U.S. medical schools have, over the past century, for complex historical reasons, organized themselves into faculty practice plans and owned and operated clinics and hospitals. They have done this to better advance their mission, create needed learning and research opportunities, and meet safety net care needs, as well as to provide financial resources. At the same time, they compete in the same marketplace as for-profit and other not-for-profit hospitals, clinics, and physician practices. However, in so doing, they undertake financial responsibilities and ancillary missions few of their competitors face.

Teaching hospitals are only 6% of U.S. hospitals, yet they provide 20% of inpatient care, more than one-quarter of all Medicaid care, and more than 40% of all hospital charity care in the country. Additionally, they are historically committed to costly, specialized resources, operating 40% of all neonatal ICUs and 75% of all burn centers. They maintain specialized units where, for example, Ebola patients returning from Africa can be treated successfully.[27]

In short, AHCs pursue unique missions and sustain unique types of capacity that are highly desired by society. In the panoply of American health care, they serve roles that must be protected even as consolidation in the clinical care sector proceeds. Proactive and attractive partnerships will be, for many AHCs, critical to thriving in this new environment.

IV. Implementing Partnerships

Success factors
In their analysis of successful and unsuccessful teaching hospital mergers, Thier and colleagues[17] identified several stages of assessment, planning, and implementation that we believe apply analogously to successful partnerships and other kinds of joint ventures involving AHCs. Not surprisingly, common themes highlight leadership, communication, trust, and cultural fit—with the understanding, buy-in, and engagement of physicians being the most critical single item of all in determining ultimate success or failure.

Thier and co-authors—each of whom led or participated in the successful mergers of the 1990s in Philadelphia, Boston, and New York City mentioned earlier—identify several necessary preconditions[17]:

- Focusing on leadership and trust—within each merging entity and between the merging entities. "Hard decisions are required, and those in management must enjoy the confidence and trust of their trustees, medical staff, and employees." There must be clear agreement and identification of who the executive leaders are. Trustees on each side need to understand, support, and completely buy in to the new organization.
- Managing uncertainty—knowing mergers are inevitably disruptive, at best, puts a premium on communication and transparency of process. "Communication is such an essential foundation of transparency that we have concluded it is essentially impossible to overcommunicate."
- Ensuring medical staff stability—providing for the stability of faculty practice plans and providing organizational certainty for physicians are critical. "In every merger we have studied, medical staff dissension has been the most volatile and difficult variable to manage."
- Bridging culture—the self-understandings and egos on each side of the combined entities must be aligned. Management styles can differ from institution to institution and should be accommodated in communicating and pacing the implementation. Differences in governance (e.g., public and private) can be especially difficult to overcome.
- Maintaining correct pace of integration—this should be informed by how great the cultural differences are between the two institutions. "When greater cultural and interpersonal alignment exists, greater near-term integration is possible. Where significant cultural gaps exist, integration should be more patiently managed. . . ."

V. Advantages and Opportunities: Range of Affiliations

As described previously, an enormous spectrum of potential relationships is possible, limited fundamentally only by the goodwill and interest of two willing partners. They include acquisition/mergers, partnerships, affiliations, and joint ventures of many degrees of complexity and "stickiness." They may be defined deliberately as stepping stones to eventual merger, or they may have periodic exit ramps available to both sides. All of these approaches could work; all could fail.

Bidirectionality—what AHCs should be prepared to provide
What AHCs should provide, or be prepared to provide, may vary immensely from place to place. It can include staffing—sending cardiac surgeons to operate in independent hospitals or clinics, with the expectation that the most complex cases will be handled at the AHC's owned hospitals. Such arrangements can further the mission, extend goodwill, improve case mix for both facilities, and create additional clinical settings that are increasingly critical for health professional education and training—not just undergraduate and graduate medical students, but also nurses and a wide range of other health professionals. Among many other services or values that could be provided by AHCs are IT support and systems, quality assurance expertise, rapid access to quaternary care and clinical trials, continuing medical education, group purchasing, and still more.

AHCs can extend the brand, in whole or in part, depending on the depth of the relationship, and usually subject to carefully defined controls. Experience in negotiations by many AHCs shows that academic brands are coveted by many independent hospitals. They are differentiators that may make a critical margin of difference to patients, staff, or donors. There does not seem to be any algorithm in the literature that assigns a dollar value to an AHC brand, as there might be in the merger or acquisition of two publicly traded companies with well-defined consumer brands. The test therefore tends to be empirical, but neither AHC boards nor CEOs should extend their "halo" cheaply. Indeed, it might be helpful to include an attributed value of the AHC brand during negotiations in description of the assets contributed by each partner.

Bidirectionality—what AHCs should receive
What AHCs stand to receive from these relationships should be understood. A wide range of current and future patient referrals—especially in the volume and complexity needed to support a research-intensive AHC—can be nurtured by good relationships with community providers.

AHCs that have experienced success in building networks, affiliations, and partnerships often look first to the most basic financial criteria to confirm that prospective partners have sufficient financial strength to remain viable if AHC leaders and faculty are to invest significant effort in a partnership. How many days' cash on hand do they have? What is their operating margin? What

is their debt-to-asset ratio? How big is their asset base? What are the anticipated "funds flows" between the partnering entities?

But in our experience, AHCs should also focus on culture and leadership fit between the organizations. What is their culture like? Have they worked with any other academic institutions? Are they managed top-down or collegially, with active physician participation? Could our CEO work well with their CEO? What is the relationship of board chairs and governing bodies? Understanding these complex issues may be more difficult, but even more important than financial details. Understanding similarities and differences between local communities, the degree of patient trust, and issues of history, culture, and economics all come into play.

AHC leaders should ask themselves candidly what is likely to happen after a possible joint venture, affiliation, or member substitution. Is the community hospital low-capacity, and is there potential to increase capacity and, hence, the hospital's margin? Or is the move to affiliate with an AHC going to rile the local competition (say a local high-quality tertiary-quaternary hospital) into more physician acquisition and open competition when the community hospital referral patterns change? Or will it be possible for the referral patterns to actually change? Maybe it won't be possible to the extent hoped by the academic partner. Does that matter? All of these consequences must be anticipated as accurately as possible, with realization that these factors are unpredictable and likely to evolve as the relationship evolves. Last, is there a goal of research collaborations (especially around clinical trials)? What degree of participation will the non-academic partners have? What might make the trials successful or not?

In a partnership setting, there will be important distinctions as to what is available to integrated versus affiliated partners. **Table 6** shows how one AHC has approached this distinction.

Table 6. **Illustrative AHC Partnership Model**

Access for Fully Integrated Partners	Access for Affilated Partners
■ Fully-integrated finances: AHC capital for investments	■ Shared financing of joint investments
■ Ability to borrow money at AHC-driven rates	■ AHC care network: clinically integrated network contract opportunities for physicians
■ AHC care network: clinically integrated contract opportunities for physicians and hospitals	■ Recruitment of candidates from AHC's residency and fellowship programs
■ Recruitment and placement support of candidates from AHC's residency and fellowship programs and national searches	■ Joint venture opportunities
■ Joint service line planning and medical staff development plans	■ Leases and professional services agreements
■ Fully integrated ambulatory facilities	■ Joint solutions to share clinical and financial information across systems
■ Joint ambulatory growth strategy development	■ Joint purchasing initiatives
■ Electronic health record implementation under AHC license	■ Introductory Lean training and best practices sharing
■ AHC pricing and vendor-negotiated rates	■ Specific co-branded clinical programs
■ Lean method coaching and project support	
■ Integrated branding approach that recognizes the value of each brand	

VI. Leadership Issues

Successful health care organization collaborations of all types require top-to-bottom support, beginning with the boards and CEOs (see Thier and colleagues[17]). CEO leadership needs to be both vertical (within their own organizations) and horizontal—that is, extending to the CEO's counterpart in a credible and reliable way. As has been said, it may be impossible to over-communicate in the service of transparency, understanding, and buy-in.

But in health care organizations, perhaps the most crucial components of all are the physician work forces—the faculty, in the case of an AHC, and their professional counterparts in the other partner. Indeed, in Blue Ridge Group discussion, it was clear that many AHC leaders are most concerned about the engagement and alignment of their faculty as the key performance factor in the overall success of any AHC. They are also concerned about the extent to which the rapid pace of change through partnerships from affiliation to acquisition may be one last straw added to the burdens of overworked faculty who are charged with teaching, grant-writing, publishing, and delivering care in an ever more complex and demanding environment. With clinical tracks growing rapidly in most institutions, AHCs must grapple with the question of where the academic track ends and with defining its relation to the branded but non-faculty clinician.

Considering structural issues from the standpoint of organizational change theory, Thomas D'Aunno distills the process of collaboration between two new health care organizations to three principal phases: "communicating the need for change, mobilizing others to accept change, and evaluating the implementation of change projects.[28]" These processes need to be conducted by managers who are proficient in task-oriented (technical) skills, as well as managers who are proficient in people-focused (communicative, motivational) skills.

In **table 7**, D'Aunno lays out a taxonomy of best practices for leadership in collaboration among health care organizations.[28(p248)]

In the opinion of many who have led and lived through AHC mergers, most of the outcome will hinge on the critical role of physician leaders. Everything else is secondary. It is clear that for successful partnerships to emerge, both sides must include leaders and managers who possess the full array of skills needed as a team, if not, understandably, the full array in every person. These attributes and skills capture the broad range and difficult nature of leadership challenges that must be met successfully as a necessary condition of giving a new relationship the chance to find its footing and flourish.

VII. Legal Issues and Considerations

Given that health care is one of the most highly regulated of all industries, one of the most indispensable members of any AHC leadership team is the general counsel. AHCs must be constantly mindful of the ever-changing and evolving legal and regulatory landscape and considerations relevant to potential expansion or affiliation opportunities. Legal and regulatory considerations inform how AHCs can (1) interact with potential or existing referral sources, (2) navigate payer and supplier contracting matters, and (3) structure potential mergers, acquisitions, joint ventures, regional collaborations, and contractual affiliations with other health care providers. AHCs should work with their general counsels to identify and address the following key legal and regulatory matters related to any potential relationship, including affiliations or partnerships:

Governance and state law matters

The governance structure of the AHC, including whether the AHC is private or public and the AHC's contractual obligations with its affiliated institution, will inform the legal considerations and regulatory parameters for potential expansion efforts.

Governance and control of the AHC in evaluating opportunities—Public AHCs, including county or state-funded or state constitutionally created AHCs, may have state or local county procedural matters to address when considering any expan-

Table 7. **Best Practices for Leadership Collaboration**[28(p248)]

Technical Leadership Tasks	Best Practices
Plans and protocols for change	**Blueprints are needed to manage complexity and promote due diligence and effective decision making by leaders of change (e.g., conducting thorough pre-merger assessment of potential partners).**
Technical capacity building	**Investment (time, money) is needed to build capacity for improved performance**
Structures and systems to support change	**Structures (especially incentives) and systems (especially information systems) are needed to promote change and to improve organizational performance.**
People-Focused Leadership Tasks	Best Practices
External pressure	**In most cases, external pressure/support for change increases both its speed and likelihood of success.**
Buy-in from all levels; critical role of central authority and shared vision	**Support from top managers and leaders is essential, but buy-in is also needed from lower-level staff; a centralized group with authority for implementation of changes is critical, especially to develop a shared vision and goals for change.**
Communication	**Communication is needed at all levels: What is the vision? Why is change needed? What progress has been achieved?**
Role of physician leaders	**Involvement of physician leaders, both formal and informal, in key decisions is critical to success.**
Managing tensions, trade-offs inherent in change	**Involving physicians versus respecting their time for patient care; time needed to build trust versus frustration with slow progress; building stakeholder buy-in versus building technical capacity (especially when buy-in and trust are enhanced by demonstrated technical capacity and improved performance)**
Core versus peripheral organizational features	**Change in peripheral features of organizations, including management and support services, is easier to achieve than change in either core clinical services or organizational culture.**

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sion efforts, including getting appropriate approval from state or local officials, state attorney general offices, and other stakeholders. Often, these state procedural elements include public meetings and open records laws, involving requirements for public notice and opportunities for government and public stakeholders to comment on or approve the actions contemplated by the public AHC. While public AHCs may be more restricted by virtue of the composition of their boards and state or local legal requirements, all AHCs, public and private alike, must consider state law considerations, such as certificate of need (CON) or other licensing laws. Moreover, both private and public institutions

must procedurally align with and obtain buy-in from their parent institutions. The extent to which the parent institution has control over the operations and decision-making of the AHC will play a key factor in the ability of the AHC to expand its “footprint” without obtaining necessary approvals. Ultimately, public AHCs may have less of an ability to be nimble, given potential decision-making restrictions by the state or local government and the timing with which those approvals can be received.

Governance and control in connection with affiliation—The desired amount of control, either by the AHC or in tandem with obligations to its affiliated university or parent entities, will also inform the legal structure of affiliations. The spectrum typically ranges from the largest amount of control residing in building/ownership and merger/acquisition models, to shared governance models in joint ventures, to the least amount of control in connection with more loose, contractual affiliations (including, service line affiliations, contractual collaborations, or management relationships).

- Mergers and acquisitions: The decision to merge with or acquire a community provider involves a number of legal and regulatory considerations, including but not limited to the following:
  - who is the surviving entity—in this instance, most likely the AHC
  - whether the arrangement is an asset or member substitution/stock transaction
  - antitrust issues (further outlined in subsequent text)
  - employees, including collective bargaining arrangements and employee benefit matters
  - access to capital and potential bond financing
  - federal and regulatory filings, notifications, and considerations regarding whether to assume the Medicare provider number
  - potential assumption of liabilities and contracts

Mergers and acquisitions offer the most control for the surviving entity, but the difficulty of unwinding is great, and the potential liabilities and risks assumed can be substantial, including determination of the resulting C-suite members from each entity.

- Joint ventures: Joint ventures involve similar considerations as those aforementioned, with the level of ownership in the joint venture likely dictating some of the considerations, such as level of control, managed care contracting, and regulatory notifications. A joint venture can be structured in a myriad of ways with silent partners and equal or unequal decision-making and/or operational responsibility, so it is imperative that the parties’ vision and goals align to ensure that the entity will be successful. Creation of joint ventures may also have state and federal tax implications for the forming entities, depending on the business purposes and tax status of the relative partners, and could result in unrelated business income for not-for-profit entities. Joint ventures provide the opportunity to partner without assuming full ownership risk and financial liability.
- Affiliations: No two affiliation arrangements are alike. Each affiliation arrangement, including service line affiliations, contractual collaborations, joint operating agreements, management arrangements, and CINs, require careful contracting and legal attention to ensure the following:
  - clearly delineated rights, responsibilities, and decision capacities of the contracting parties as well as remedies and processes for potential breach and resolution (to hopefully avoid conflict and deadlock situations)
  - preservation of any ownership, confidentiality, or intellectual property rights of the respective parties
  - specification of the fee and payment obligations
  - clear representation of goals of the affiliation
  - detailed understanding of the methods for, and triggers of, unwinding or terminating the relationship

Regarding the latter, such arrangements often start with a limited duration of time and may include triggers that dissolve the affiliation and return the parties to the prior status quo. Ultimately, contractual affiliations afford parties the opportunity to collaborate and leverage economies of scale while preserving autonomy and identity.

Antitrust implications

In essence, antitrust law is applied microeconomic and industrial-organization economic theory

Table 8. **Recent Examples of Antitrust-Related Cases**

Merger Issue	Government Challenge	Status
St. Luke's Health Systems, Ltd. (Idaho) to divest ownership of Saltzer Medical Group, P.A.[33]	In 2015, the Ninth Circuit upheld the FTC's and Idaho state attorney general's challenge to require St. Luke's to divest Saltzer, an independent multi-specialty physician group it had acquired, finding that the relevant geographic area was Nampa, Idaho, and there were anticompetitive effects for the adult primary care market and insurers needed to be able to include competitive options for primary care physicians in their networks.	In 2015, the Ninth Circuit upheld the FTC's and Idaho state attorney general's challenge, and St. Luke's Health Systems, Ltd. divested Saltzer Medical Group, P.A.
St. Mary's Medical Center's acquisition of Cabell Huntington Hospital in Huntington, West Virginia[34]	In 2015, the FTC challenged the acquisition, alleging in its complaint that the resulting entity would create a "natural monopoly" over general acute care inpatient hospital services and outpatient surgical services in the relevant geographic market with a post-acquisition market share of 75.4%. St. Mary's Medical Center and Cabell Huntington Hospital entered into an Assurance of Voluntary Compliance with the attorney general of West Virginia to limit for seven years certain conduct by the combined entity, including price increases—the FTC in its complaint alleged this as an attempt to void an antitrust challenge.	In response to the FTC challenge, the West Virginia legislature passed a law in 2016 exempting certain hospital mergers from federal antitrust laws if the West Virginia Health Care Authority approves the merger—the West Virginia Health Care Authority approved St. Mary's Medical Center's acquisition of Cabell Huntington Hospital in June 2016, and the FTC voluntarily dismissed its complaint shortly thereafter.
Merger between Penn State Hershey Medical Center and PinnacleHealth System in Harrisburg, Pennsylvania[35]	In 2015, the FTC and the Pennsylvania Office of the Attorney General challenged the proposed merger, alleging that the two providers operate the only three hospitals in Dauphin County and offer an overlapping range of general acute care services, including primary, secondary, tertiary, and quaternary care. The complaint alleged that the post-transaction entity would have market share of 64% and reduce the number of meaningful competitors in the Harrisburg area from three to two.	After vigorous debate with the FTC, as of October 2016, Penn State Hershey Medical Center and PinnacleHealth System abandoned their efforts to pursue the merger, and the case was dismissed.
Merger between Advocate Health Care Network and NorthShore University Health System in the Chicago area[36]	In 2015, the FTC (later joined by the Illinois attorney general) filed a complaint to block the proposed merger, alleging that these are the two largest providers, based on admissions, general acute care inpatient hospital services in the area (defined by the FTC as North Shore Area), and the fact that the proposed merger would create the largest health care system in the North Shore area with a market share of 55%. Notably, the FTC's definition of the regional area as the North Shore area greatly narrows the covered geographic location to a subset of the greater Chicago area.	After receiving a ruling granting the FTC's and state of Illinois' request for preliminary injunction to block the merger on March 7, 2017, Advocate Health Care Network and NorthShore University Health System announced their intention to abandon their efforts to pursue the merger.

constructed by federal civil and/or criminal statutes, and potentially corresponding state laws, which aim to protect and promote competition as a method by which the U.S. allocates resources by prohibiting (1) arrangements that unreasonably restrain competition,[29] (2) monopolization, attempted monopolization, or conspiracies to monopolize,[30] (3) mergers and acquisitions that may reduce the level of competition in the marketplace,[31] and (4) unfair methods of competition.[32] The Federal Trade Commission, Department of Justice, and state attorneys general enforce this antitrust rubric in the health care arena with a keen focus on conduct and transactions that increase market power for providers within specific geographic markets, with the result that deals have been abandoned or unwound or are still in court. A few recent examples of such cases are found in **table 8.**

While the examples in table 8 largely pertain to regional health system consolidation and physician group acquisitions, they are instructive for AHCs, as the FTC will view AHCs as a competitor to other hospitals' or health systems' market share in their geographic market. These examples, like the plethora of examples before them, continue to show the importance the FTC places on (1) the relevant geographic market—with markets as narrow as one city or subset of a metropolitan city (i.e., St. Luke's in Nampa and Advocate in the North Shore Area of Chicago), (2) individual products or service line market share (i.e., St. Luke's adult primary care and the numerous overlapping services in Harrisburg between Pinnacle and Hershey), and (3) opposition by payers to the transaction (St. Luke's anti-competitive effect on insurance providers). Further, St. Luke's in Nampa, Idaho, demonstrates the FTC's willingness to leave no health care provider untouched, so even physician practice group acquisitions that do not meet mandatory reporting thresholds may receive scrutiny.

State attorneys general often work in concert with the federal antitrust agencies and continue to scrutinize post- and pre-merger activity in health care for any market changes that affect hospital costs and price increases for anti-competitive effects. However, strong state support, such as in West Virginia for St. Mary's acquisition of Cabell, demonstrate that state governments and advocacy can play a role in the antitrust landscape through the use of Certificate of Public Advantage (COPA) laws which preempt federal antitrust law. Use of COPA laws may be helpful for AHCs who already have ties to state authorities as COPA laws may provide a mechanism for exemption from federal antitrust laws. In practice, the COPA laws substitute a state regulatory practice for a federal enforcement process and often introduce a supervisory requirement by a state regulatory agency. While the FTC has recognized the effectiveness of COPA laws, the FTC has expressed that COPA laws can facilitate anti-competitive mergers and may not always defer to such state statutes.[37]

In recent years, affiliation relationships that create their bonds through clinical care delivery and not financial integration (e.g., CINs) are an option being considered in many areas. Along those lines, many AHC strategies understandably are aimed at forming and extending CINs and joining both employed and independent physicians to the AHC's network. AHCs should look to the body of FTC Advisory Opinions on structuring CINs to ensure that the arrangement is sufficiently integrated to permit contemplated joint conduct such as payer contracting.

Early in 2016, a troubling opinion pierced a hole in the protection afforded to joint operating arrangements between providers. The Sixth Circuit found that four hospitals (Good Samaritan Hospital, Miami Valley Hospital, Atrium Medical Center, and Upper Valley Medical Center) that had formed a joint venture through a joint operating agreement were competitors who conspired to eliminate another competitor (The Medical Center at Elizabeth Place), instead of a single entity incapable as a matter of law of conspiring in violation of the antitrust laws. In other similar cases, courts have found that the joint venture represented a single entity and that the member entities were unable to conspire. But in this case, focusing on what some antitrust experts believe is the wrong legal analysis, the court found, based on an external consultant's strategic plan, that each of the member hospitals operated independently within the joint venture (e.g., they retained their own assets, identities, and economic

interests) and that the joint venture developed no real identity.[38] Given this precedent, AHCs, like all health care providers, should be mindful of the antitrust risks when forming any type of joint operating agreement or other joint venture with a competitor or potential competitor and must set up appropriate firewalls and put into place necessary antitrust protocols.

AHCs should work with their general counsel to identify antitrust pitfalls prior to employing any expansion strategies as each case is complex and fact-specific to the market—and the FTC will not hesitate to bring a challenge.

Fraud and abuse compliance

As AHCs find innovative ways to extend their reach, it is critical to remain mindful and cognizant of federal and state fraud and abuse laws. Often, there is a misconception that, if a party is an "affiliate," then these laws do not apply. However, the opposite is true—the closer the connection, the more careful the parties should be to ensure that there are no improper perks or benefits running between them. Even a seemingly innocuous benefit may be subject to later scrutiny by the government to determine, through an email and document review, whether either party had an improper purpose (related to referrals or health care program business generation) related to that benefit. Ultimately, all arrangements between referral sources must reflect fair market, arms-length negotiation and exchange of value.

The parties to such arrangements must be cognizant of several federal laws, among others:

- The Stark Law,[39] a strict liability civil statute that prohibits a physician (or a physician's immediate family member) with a financial relationship with an entity from making referrals to that entity for designated health services,
- The Anti-Kickback Statute,[40] an intent-based civil and criminal statute that prohibits knowingly and willfully offering or receiving remuneration (i.e., something of value) in an effort to induce or reward referrals of items or services reimbursable by federal health care programs,
- The False Claims Act,[41] an intent-based civil statute that prohibits knowingly submitting or causing another to submit false claims or record to government for payment of a claim. The False Claims Act is the primary civil enforcement tool used by the government, and suit may be brought by either the government or a private party whistleblower (e.g., a *qui tam* relater), who receives a percentage of any settlement or damages. The False Claims Act carries the potential for treble damages and per-claim penalties ranging from $11,000 to $22,000.

Finally, states typically have similar laws to the federal fraud and abuse laws, and some of these laws broaden the scope of applicability not just to federal/state health care programs but also to private payers and to self-pay business.

AHCs, like all health care providers, should structure affiliation arrangements to comply with an exception to the Stark Law and if possible, to fall within a safe harbor to the Anti-Kickback Statute. For AHCs considering acquiring a community provider, performing an intensive, due diligence review of compliance with fraud and abuse areas is vital in order to ensure that any potential liability or risk remains the responsibility of the selling entity (and is typically disclosed to the government as a condition to close). There is an academic medical centers exception[42] to the Stark Law that assists AHCs with funds-flow management between the components of the AHC and its physicians; however, this exception is highly technical and complex so the parties must be intentional in how they set up any arrangement that seeks to comply with this exception. Since the academic medical center exception keys off of the fact that substantial activities of the arrangement support the academic mission, incorporating non-academic elements may dilute the facts to the level that the exception no longer applies.

Additional considerations

In addition to the key concerns outlined in the preceding text, AHCs should coordinate with their legal counsel to resolve any privacy matters, including HIPAA and state law; state law matters, including CON or other licensing limitations; and tax implications and financing mechanisms, including any bond financing for not-for profit AHCs. Many if not all outreach efforts by AHCs involve leveraging the brands of the parties, so careful evaluation and protection should be put in place by the parties to maintain the intellectual capital that each parties' brand brings to the deal—and in particular ensuring that the AHC's brand is not diluted.

Table 9 provides a regulatory map of certain key issues to consider when AHCs are contemplating expanding their footprint.

Table 9. **Key Regulatory Issues to Consider in Expanding AHC Footprint**

Model	Legal and Regulatory Considerations
Building and owning	■ Financing, including bond financing and raising capital ■ Acquiring real estate
Mergers/acquisition	■ Antitrust ■ Financing, including bond financing and raising capital ■ State and local procedural matters for public AHCs ■ State laws, including CON ■ Intellectual property rights/branding ■ Obtaining contractual consents ■ Negotiating asset acquisition ■ Changing governance structure for the expansion effort ■ Fraud and abuse
Formal joint ventures and contractual partnerships (including franchising, service line affiliations, general affiliation agreements, contractual collaborations, and care coordination)	■ Governance of the AHC ■ Governance/control of joint venture/affiliation ■ Tax implications (i.e., impact of not-for-profits working with for-profits and creation of subsidiary entities) ■ Fraud and abuse ■ Intellectual property rights/branding ■ Protected health information and data privacy ■ Compliance
Physician referral networks/clinically integrated networks	■ Fraud and abuse ■ Antitrust ■ Compliance

VIII. Case Studies

BJC Collaborative: An overview[43]

Sometimes being big is not enough; you have to be geographically distributed with a comprehensive array of service offerings and access points in order to achieve your strategic goals.

That's roughly the position BJC HealthCare found itself in four years ago, when it set out to bookend its geographic footprint in St. Louis, Missouri, with two wide arcs, one covering Missouri, the other much of Southern Illinois. The moves were made in furtherance of higher-quality care for patients as well as cost savings, long-term positioning goals, and infrastructure initiatives that could be enabled by roughly doubling in scale.

BJC is the host health system for an adult teaching hospital and a pediatric teaching hospital, both affiliated with Washington University School of Medicine in St. Louis, creating one of the nation's largest academic medical enterprises. Steve Lipstein, president and CEO of BJC HealthCare, serves on the university's board, and the univer-

sity's chancellor and executive vice chancellor for medical affairs serve on BJC's board. By itself, not including the university's employed physicians and associated practice plan, BJC has 15 hospitals and just under 30,000 employees.

In developing the collaborative, BJC was steered by three criteria: it was looking for academically affiliated hospitals, health systems in positions of both market and financial strength, and geographic representation to cover the major population centers in Missouri and Southern Illinois.

Beginning in October 2012, there were four founding members of the BJC Collaborative:

- BJC HealthCare, St. Louis, affiliated with Washington University School of Medicine
- Cox Health, Springfield, Missouri, affiliated with University of Missouri-Columbia School of Medicine
- Memorial Health System, Springfield, Illinois, affiliated with Southern Illinois University School of Medicine
- Saint Luke's Health System, Kansas City, MO, affiliated with University of Missouri-Kansas City School of Medicine.

Since then, the collaborative has added four participant organizations (see **figure 2**):

- Southern Illinois Healthcare, Carbondale, Illinois
- Blessing Health System, Quincy, Illinois
- Sarah Bush Lincoln Health System, Mattoon, Illinois
- Decatur Memorial Hospital, Decatur, Illinois

A key feature of the collaborative's growth was to add members through "participation agreements," not outright purchase, because to buy all of these health care facilities and provider organizations would have drained BJC's cash reserves—which are needed for renewal and expansion of its own patient care infrastructure.

Four years on, the eight collaborative members have total revenues of more than $10 billion, as compared with the $5 billion that BJC registers by itself. BJC has provided approximately $500,000 of the collaborative's overall $2.4 million for start-up and operating costs, while its share of the total $215 million in savings to date is $147 million. The savings derive largely from clinical asset acquisition and management ($131 million), information technology ($21 million), and supply chain/contracted services ($26 million). "Most people would agree it's been a pretty good investment," says Lipstein.

Figure 2. **BJC Collaborative**

One of the collaborative's top priorities for 2016 is to pursue further savings through Mid-America Service Solutions, a supply chain organization owned in part by five of the collaborative's members and in which all eight of them participate. From inception to date, members have achieved $26 million in savings, and are now focusing on six key areas: bone cement, suture/endomechanics/trocars/topical skin adhesives, electrophysiology, cranio-maxillofacial, orthobiologics, and orthopedic joint implants.

Even greater savings have been achieved through bundled purchases of clinical equipment, including procurement, servicing, and training costs, with $131 million savings to date, much of it accomplished by taking advantage of the dollar quantity and timing of purchases enabled by the collaborative's size and coordinated interface with vendors and suppliers.

Looking ahead, an initiative called Collaborative Care Management Resources (CCMR) promises to be transformational. Six of the eight collaborative systems have come together to contract with IBM Watson to create a data integration hub with a shared data repository and a Watson-sophisticated analytics engine. The output of information will be coupled with new and better care management and coordination models to produce better health care outcomes at lower cost. CCMR will support "total cost of care" management and risk contracting, says Lipstein, enabling improvements in care coordination for patients through the development of protocols. Included will be risk profiles, disease registries, care management workflows, provider panel analytics, performance metrics, and cost of care information.

It is becoming clear what kinds of analytic insight, financial capacity, and management expertise will be required for assuming financial risk and taking responsibility for the health outcomes of large defined populations of patients—in other words, for moving from the theory to the practice of population health, a long-term goal of health reform in general and the Affordable Care Act in particular.

Lipstein acknowledges that accepting and managing population risk on a large scale is a big step for any academic health center, and one that carries uncertainties whose true magnitude can only be quantitatively defined when a sophisticated informatics system like the one BJC Collaborative is building now is put into place. "If you don't understand the magnitude of the financial risk and if you haven't already implemented new care delivery models to manage that risk, AHCs would be ill advised to think themselves well equipped to manage population health."

Vanderbilt University Medical Center: Academic health system reorganization and affiliated network development[44]

In 2016, Vanderbilt's health system separated formally from Vanderbilt University. But the split was and is an entirely amicable one, says Jeff Balser, president and CEO of the Vanderbilt University Medical Center (VUMC). It was initiated by the university's board, with behind-the-scenes research and discussions having begun several years previously, a considerable time before the dramatic move became public.

And, says Balser, so far the new arrangement is working just as both parties hoped. While continuing to share the Vanderbilt name—along with many formal as well as informal organizational and personal ties—university and medical center now each have their own boards, their own budgets, their own CEOs, and their own freedom of action.

The university president and trustees no longer have to worry about a health system with a $3.5 billion budget putting them at unexpected risk in a sudden downturn. They are free to devote their energies to oversight of the liberal arts and other parts of the university. At the same time, the medical center has streamlined its governance and decision-making processes, enabling it to more quickly make the strategic moves required to remain agile in a rapidly changing health care world. When it came time to get approval, because Vanderbilt is private, only the state attorney general needed to sign off on the change. And his question was whether VUMC would continue to see and treat the same number of uninsured patients. The answer was yes.

Communicating the change—what it would

and would not mean—was extraordinarily time-consuming but critical to success. Communication was critical because the clinical departments and their faculty joined the new VUMC for their education, research, and clinical activities. The faculty in the clinical departments were university employees in the past but are now employees of VUMC. Extramural research funding in the clinical departments previously went through the university and now goes directly to VUMC. Beginning about 18 months before the close on the divestment, which occurred in April 2016, Balser and the university provost made presentation after presentation. He estimates they did 60 town hall meetings in all.

Not the least delicate part of the operation was assuming the university's debt on medical center buildings, which required placing about $980 million in bonds. Although medical center leaders were holding their breath, they were rated at A3 by Moody's. And when the bonds went up for sale, they were over-subscribed by eight times within a few hours.

That was a powerful lesson, says Balser: an AHC's name, its brand, quite likely has more goodwill and equity packed into it than leadership may fully appreciate. It turns out even bankers acknowledge and respect the achievement and promise of academic medicine. It's worth something.

Governance of VUMC is complex (see **figure 3**). A non-controlling 30% of the medical center's board is composed of university trustees. In addition to being president and CEO of VUMC reporting to the VUMC board, Balser is dean of medicine, in which hat he continues to report to the chancellor of the university for medical school functions that VU retained in the reorganization, such as faculty appointments and degree-granting student programs. VUMC went from generating 83% of the university's budget to 15% as a separate entity. The medical center continues to run research animal services and IRBs for the university, and the two entities share a campus security force. Yet by decoupling functions like HR, development, and the general counsel's office, VUMC officials got the ability to make strategic moves in a matter of weeks that formerly might have taken them months to get approved.

Figure 3. **Medical Center Reorganization**

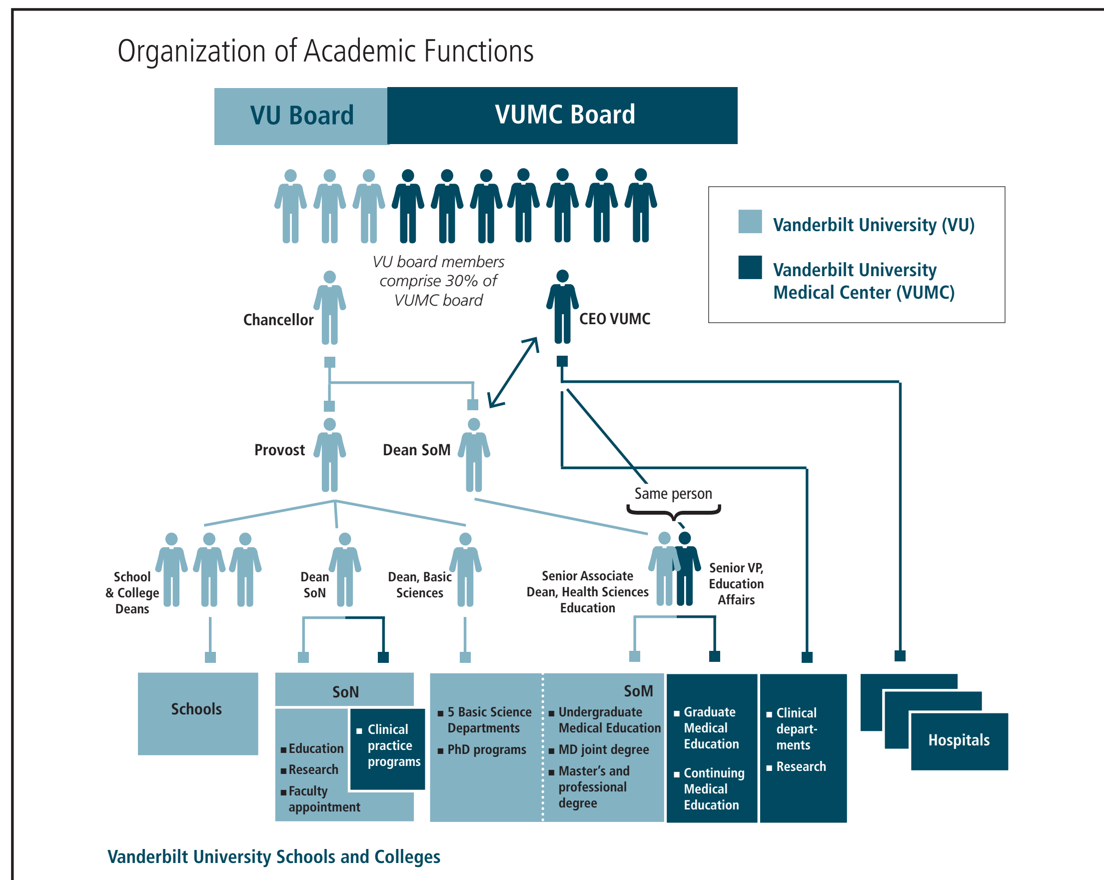
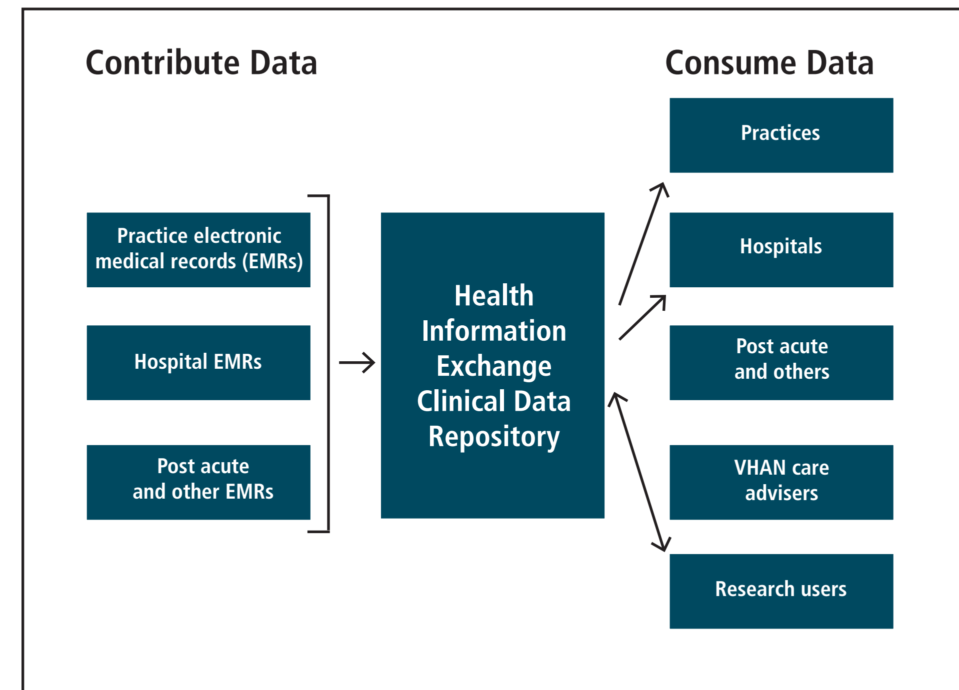


Figure 4. **Vanderbilt Health Affiliates Network** (VHAN)
Health Information Exchange and Technology Platform



And all of that is for the good, as VUMC pursues ambitious business goals that will ultimately enable it to address population health needs in one of the most unhealthy regions of the country. Statistics show that life expectancy in large swaths of the Southeast is more than four years less than the average for Organisation for Economic Co-operation and Development high-income countries. Part of that is due to the persistence of smoking and poor diet, says Balser, but part of it is also due to failures of a fragmented health system to deliver care in a connected, coordinated way.

Vanderbilt aims to change that. It is pursuing a growing, regional affiliation. Lacking the money to buy systems outright, it is affiliating with them. "Necessity is the mother of invention. We are out making friends," says Balser.

Vanderbilt has formed and is growing the Vanderbilt Health Affiliated Network (VHAN), currently including 12 systems and 56 hospitals. In a tiered system, it extends cost savings to all members and offers a health plan, with Aetna, which currently covers 125,000 lives, including employees of affiliate members. The aim is to extend it to 500,000 covered lives in the next three to four years.

In efforts analogous to the IT infrastructure core being built by BJC Collaborative, Vanderbilt is leveraging its experience and leadership in health informatics technology to develop a health information exchange, or HIE, to connect its affiliated members and on-campus programs, with care improvement and cost-savings as the primary goals. The clinical and genomics research strengths of VUMC will also be extended to VHAN through the HIE (see **figure 4**).

Emory Healthcare: Pursuing affiliations and a network strategy[45]

With net patient services revenue of $3 billion, hospital discharges of more than 70,000, and total

outpatient visits of more than 4.3 million, Emory Healthcare is one of the largest comprehensive health care systems in metro Atlanta and the state of Georgia.

Yet, after a year in which a potential merger with not-for-profit hospital chain WellStar came up short, Emory is creating a strategy of building networks through partnerships and affiliations with both hospitals and physician groups. And, says executive vice president for health affairs and Emory Healthcare CEO Jonathan Lewin, that is just the way Emory wants it.

In part, Emory's strategy reflects the unusual geography and context in which it finds itself. And that, says former EVP and CEO Michael Johns, only goes to show that when it comes to academic health care, "If you've seen one market, you've seen one market."

Georgia is the largest state, geographically, east of the Mississippi River. It is possible to drive for five hours to the southeast of Emory's location in metro Atlanta—the nation's eighth largest metro area by population—and still be in Georgia.

Yet there are only two major academic health systems in the entire state—Emory Healthcare (owned by Emory University) and Augusta University Health/Medical College of Georgia in Augusta. There are also smaller systems in Macon and Savannah.

Much of Georgia outside these areas is served by small rural hospitals and physician practices. Not a week goes by that the phone does not ring with a question from one of these smaller community assets about whether Emory would consider an affiliation or acquisition.

But, says Lewin, running small rural hospitals is not Emory's forte. And, he says, Emory has no current interest in buying and attempting to operate hospitals that might be located up to five hours away by car. About one hour's drive is the radius where acquisition is a reasonable strategy, he says.

Affiliation then becomes the most effective way to protect and maintain the referral networks for complex cases that Emory needs to maintain its tertiary and quaternary care specialties and subspecialties, as well as its undergraduate medical education and postgraduate training programs.

The general principles, in that respect, are similar to those followed by Johns Hopkins Medicine (JHM), in a presentation given by Lewin in July 2015 when he was senior VP for integrated health care delivery at JHM: Determine how large a base of complex referrals you need for your educational and research missions, and then construct a combination of partnerships and affiliations to supply it. On the scale of things, building new hospital facilities and making acquisitions of other distant hospitals are his second choice because they demand capital and require rural facility management skills that he does not believe represent the key expertise of AHC leadership.

While affiliations are critical to supply sufficient tertiary and quaternary patients, Emory has solidified the bulk of its patient volumes by developing a number of key components of the continuum of care in its networks, ranging from retail clinic management, urgent care, and ambulatory and inpatient acute care facilities, through long-term acute care, skilled nursing, and rehabilitation inpatient and outpatient services. These have been developed both through internal resource allocation and through joint ventures.

As a university-based health system, Lewin says, the first principle must always be to start with the end in mind—being able to sustain the tripartite mission of education, research, and patient care. Systems must, of course, be able to provide the highest-quality clinical care and should be building capacity and expertise to deliver value-based care.

Importantly, local and regional market competition should influence, but not determine, strategic choices because the needs and imperatives of AHCs, including their educational needs and their social responsibilities, must be served. It is a burden that for-profit as well as other not-for-profit non-academic health systems do not have to meet. Perhaps the largest example is the delivery of uncompensated care and the maintenance of clinical and education missions in public safety-net hospitals, such as Grady Memorial Hospital in Atlanta. Staffed by faculty physicians and residents from Emory School of Medicine and Morehouse School of Medicine, it is an important educational and training site for both schools and serves an incredibly important social mission but one that is challenging to maintain on financial grounds alone.

Joining Emory in February 2016, Lewin appointed a 23-member task force with three subcommittees, bringing in more than 80 additional persons (focusing on local, regional, and national/international needs) and charged them with developing a clinical network strategic framework and implementation plan. The group was charged with meeting four strategic objectives:

1. Provide sufficient clinical scale to support and sustain Emory's medical education and research missions and fund the overall academic enterprise.
2. Maintain Emory Healthcare's long-term financial viability by securing its local, regional, and super-regional roles, referrals, and market position.
3. Achieve sufficient patient volumes for both routine care and highly specialized programs to ensure the highest quality and outcomes.
4. Achieve sufficient critical mass so that Emory remains indispensable to patients, affiliated providers throughout Georgia and beyond, payers, and employers.

In pursuit of its strategy, Emory is actively exploring partnership affiliations with independent hospitals and health systems all over the state, with a focus on finding mutually beneficial relationships (see **figure 5**). In approaching potential partners, Emory's assessment criteria attempt to assess convergence between Emory's value proposition—what Emory can bring to the table—and what potential partners need, including clinical programs, supply-chain management, research collaboration, education programs, or others. In some cases, Emory is placing cardiac surgeons or other providers in other hospitals to strengthen their programs, support their independence, and create a referral pathway of more complex cases back to Emory hospitals.

Selection criteria range from the highly quantitative (inpatient discharges, payer mix, operating margin, and days' cash on hand), to the qualitative (will Emory and the organization work well together?). If a potential venture passes these optics, the affiliation then can proceed to implementation, including establishment of a joint oversight committee, creation of well-defined guidelines for use of the Emory brand, and nurturing physician-to-physician relationships between Emory and the new affiliate. Since rolling out this new initiative in the summer of 2016, Emory has brought more than 20 hospitals into its affiliated network, and is work-

Figure 5. **Emory's Strategic Objectives by Market Area**

ing to tailor the services and relationship with each to optimize their mutual benefit.

University of Michigan pursues partnership strategies to build a statewide delivery system[46]

The University of Michigan Health System (UMHS) is "a big health system in a small town," says Marschall S. Runge, executive vice president for medical affairs and dean of the UM medical school. It must pay close attention to funds flow to maintain its highly differentiated mission of research, education, and clinical service.

UMHS has one owned hospital with 1,000 licensed beds, running at more than 90% capacity; nearly 48,000 annual discharges; and 2.1 million outpatient visits. Its research program in basic, clinical, and translational research garners $417.6 million a year from external sources—but represents a total cost of more than $600 million to sustain. Fundraising is impressive, amounting to about $170 million per year—about a quarter of total fundraising by the University of Michigan.

In short, UMHS typifies the vital university-AMC relationship analyzed by Moody's in its 2016 medians report,[26] finding that universities with substantial AMCs (generating more than $50 million a year in revenues) enjoy substantial advantages in reputation, debt capacity, and bond ratings over other universities.

But as well as it is doing in its home market of Ann Arbor, UMHS faces the need to build a statewide network to secure access to sufficient numbers of patients such that it can influence health care statewide and maintain access to patients needing services unavailable in local communities. Supporting the educational analysis reported in the 2015 Blue Ridge Report,[2] UMHS calculates that it needs to influence the care of more than 3 million people in its network to sustain key clinical programs and its delivery system budget—which is, in turn, important to the university as well (see **table 10**).

"We don't need to have the biggest health system around, but we need to be indispensable to payers in the state of Michigan," says Runge. The health system market is consolidating rapidly, but from a payer standpoint, Blue Cross Blue Shield already represents about 80% of the private insurance market. Ironically, UMHS would like to own a health plan, but it doesn't—in 2006, under different conditions, UMHS sold its 200,000-member health plan to the Blues.

UMHS's strategy is to partner with health systems locally and statewide to assist those organizations in strengthening their ability to serve local communities and to build relationships with local medical communities, thus solidifying UMHS's referral base for complex cases. This strategy includes partnerships to create alternative locations to provide more routine services, given extremely high occupancy at University of Michigan Hospital. The goal is to keep care local as much as possible.

Current and potential partnerships include an interest in MidMichigan Health System, serving more than 200,000 in north central Michigan. A robust system with five hospitals as well as seven urgent care centers and two nursing homes, MidMichigan generates more than $600 million in revenue annually. Exemplifying the advantages that AMCs bring to unattached partners, MidMichigan strengthened its clinical capabilities, added luster to its reputation, and gained access to management capabilities in preparation for practicing population health.

In such a partnership, it is important to manage use of the academic brand according to agreed-upon guidelines, Runge emphasized. The "brand" of the AMC is certainly a coveted part of any such relationship, he said; a proprietary study done for a smaller hospital in Michigan showed that it could get a 25% to 30% lift by being able to co-brand itself with the UM name.

It is also important to understand the legal implications of alternative partnership models—which vary according to the type of business relationship and can also vary based on the public or private ownership models of the participants. In this case, "because UMHS only has a minority interest in MidMichigan, we are limited in our ability to act in a fully integrated manner," says Runge. "Physician and other services must be treated as arms-length transactions. Only certain financial information can be shared. We can only realize limited economies of scale; for example, IT licenses remain separate."

The advantages such arrangements hold for both sides are rooted, nonetheless, in improved

Table 10. **We Need >3 Million Lives to Sustain Our Specialty Programs**

Cumulative Percent of Current University of Michigan Inpatient Revenue Captured by Service Line

Lives (millions)	**1**	**2**	**3**	**4**	**5**	**>6**	Percent of Inpatient Revenue
Rehabilitation	100%						2%
Neonatology	100%						4%
Obstetrics	100%						3%
Normal Newborn	100%						<1%
Vascular Services	100%						3%
Neurology	99%	100%					2%
Orthopedics	99%	100%					5%
Thoracic Surgery	93%	100%					1%
Gynecology	92%	100%					1%
General Surgery	89%	100%					19%
Ophthalmology	71%	100%					<1%
Behavioral Health	97%	99%	100%				2%
General Medicine	96%	99%	100%				18%
Spine	82%	97%	100%				3%
Neurosurgery	65%	99%	100%				4%
Trauma	69%	87%	96%	100%			1%
Onc/Hema (medical)	66%	91%	99%	100%			6%
Urology	62%	91%	98%	100%			2%
ENT	49%	76%	92%	98%	100%		2%
Transplant	23%	45%	68%	89%	100%		9%
Cardiac Services	68%	86%	94%	96%	98%	100%	13%
Total	**80%**	**92%**	**96%**	**99%**	**100%**	**100%**	**100%**

Source: FY15, University of Michigan Health Service data, HCUPS use rates

patient care. For example, patient advantages can be seen in the UM/MidMichigan development of a common set of imaging protocols for robotic prostatectomies. Removing the previous need to have imaging repeated for patients who were transferred to UMHS hospitals, the common set of guidelines saves both sides money, and patients time and stress.

In addition, UMHS is pursuing a number of joint venture opportunities with local and regional hospitals and health systems. It is the majority owner of an LLC called the Physician Organization of Michigan ACO (POM ACO), which was formed by nine group practices and independent physician associations representing 5,200 providers. POM ACO serves more than 100,000 Medicare beneficiaries in a Medicare shared-savings program ACO contract. Governance is shared with all participants, while UMHS provides management services, such as data reporting and analytics.

In yet another significant venture, UMHS has become a minority participant in Together Health, formed by the Michigan ministries of Trinity and Ascension to develop population health capabilities and seek statewide contracts with payers and employers. UMHS also has a number of clinical service relationships and joint ventures with individual Trinity and Ascension hospitals across the state for radiation oncology, pediatric subspecialty services, orthopedics, and cardiovascular care, as well as educational relationships.

In addition to these affiliative activities, UMHS projects the need to invest in more than 300 additional hospital beds by 2025 to serve the Ann Arbor population.

UMHS has also completed an affiliation with Metro Health in Grand Rapids, Michigan. This affiliation was initially negotiated as a minority interest, along with provision of clinical services, similar to the MidMichigan relationship. However, both organizations determined that a "member substitution" approach would help both UMHS and Metro Health better achieve their shared objectives because it offered the prospect of closer alignment. The new relationship was completed December 15, 2016.

Among the "key lessons learned," Runge says, are the following: Try a variety of approaches, be flexible and respectful, make sure the economics are aligned across all parties, and "place multiple 'modest' bets." Like many others, he favors approaches that do not require his AMC to own and manage a large network of community hospitals, saying that is not an AMC's expertise, and he stresses the critical importance of faculty engagement in the process. To succeed, these models need faculty understanding, championing, and buy-in.

University of Chicago Medicine strategic plan for growth and transformation[47]

At the start of this decade, University of Chicago Medicine (UCM) faced a number of challenges, says Kenneth S. Polonsky, dean of the Pritzker School of Medicine, dean of the Division of Biological Sciences, and executive vice president for medical affairs.

Situated in one of the nation's largest metropolitan areas, it faced competition from health systems throughout Chicago, including four other academic health systems, as well as a large Medicaid patient mix with eroding rates of reimbursement and the necessity to pay for a $500 million bed tower.

Furthermore, UCM practice locations were largely confined to its Hyde Park campus on the south side of Chicago. (See **figure 6** for a picture of the Chicago health care market.)

Six years later, the picture has brightened considerably, following development of a strategic plan; investments in faculty recruitment; efforts to improve patient access, service, and satisfaction, and information technology; and aggressive network growth strategies. UCM still has only a small slice of a big pie, but its metrics are growing dramatically (see **figure 7**).

"We devoted considerable effort to developing a strategic plan that we have really followed in a disciplined and systematic way," says Polonsky. "There were two big buckets—growing revenue (through building networks and developing clinical service lines) and controlling costs by improving efficiency and productivity while improving utilization of our fixed cost assets, including inpatient beds and operating rooms."

Improvements were facilitated by investments in information technology, including new systems allowing UCM to make staffing adjustments up or down in a much more nimble way than was possible before. Supply-chain management also played a key role under the leadership of an experienced executive with experience in the automotive industry, leading to savings of millions of dollars.

Other major areas of focus were on transforming the delivery of care in both inpatient and ambulatory settings, improving patient safety and quality of care as well as the patient experience, and working to improve the alignment of the clinical and academic missions through a new funds-flow methodology.

The system has seen gratifying improvements in quality and patient satisfaction (garnering an "A" in patient safety from the Leapfrog Group for 10 periods in a row, making UCM one of the top 2% of hospitals nationally to hit that mark).

With 28,000 hospital admissions and 740,000 ambulatory encounters, University of Chicago Medical Center is experiencing the greatest rate of growth in inpatient discharges of any hospital in the Chicago market. Adult inpatient discharges have grown at the rate of 7.4% a year, while overall discharges are declining at the rate of 2.5% a year in Chicago and northwest Indiana.

Anticipating further consolidation in the market, growing emphasis on outpatient care, and softening rates of reimbursement, UCM has also committed itself to expansion outside Hyde Park through three principal means: hospital partnerships, ambulatory expansion in select markets, and development of the UCM Care Network—a CIN of

Figure 6. **Chicago's Market**

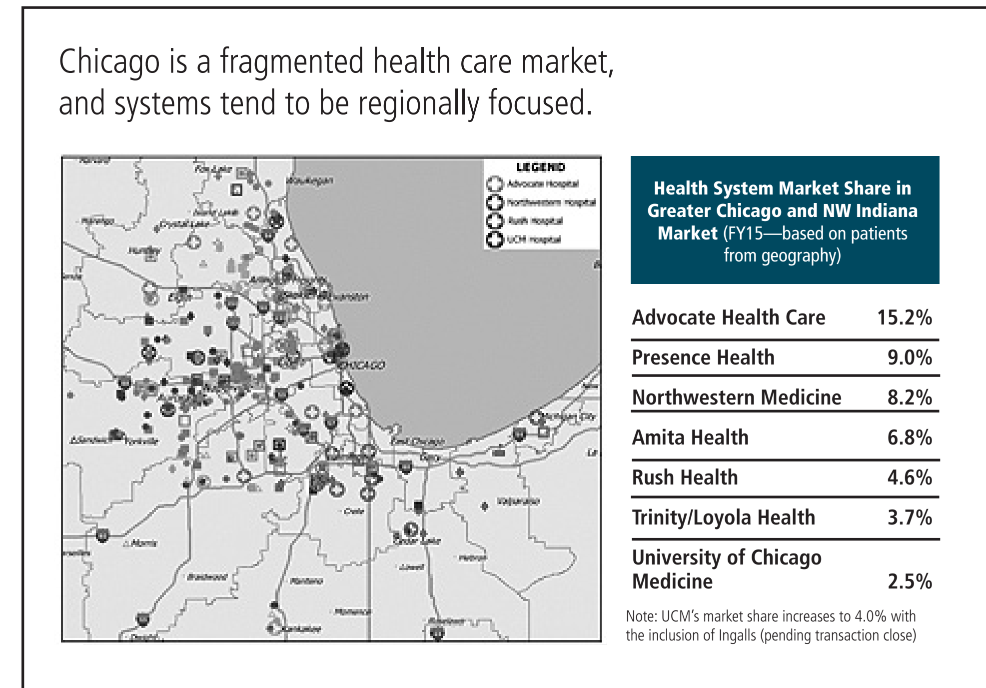
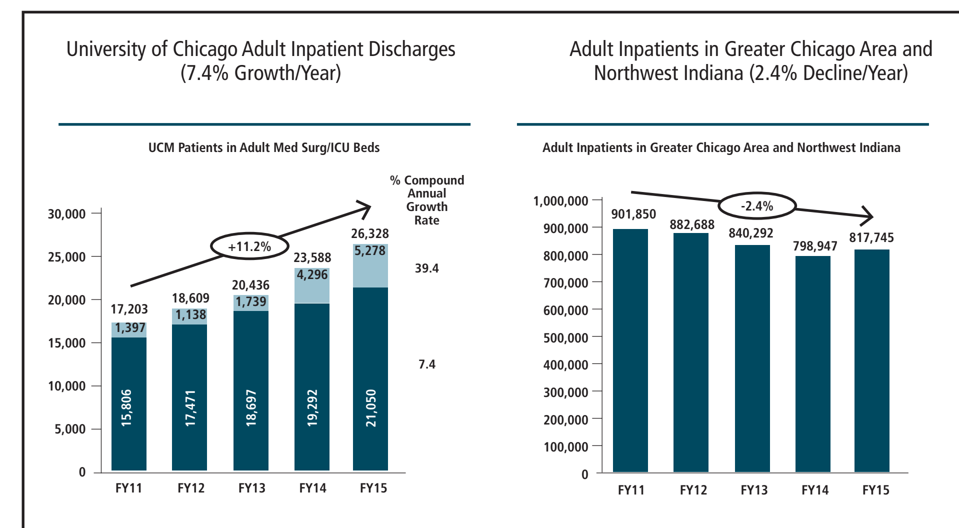


Figure 7. **Growth of Adult Inpatient Discharges in a Declining Market**



Note: Obstetrics patients are not included
Source: ADT bed census data, UCM billing data

both employed and affiliated physicians.

Although they will practice under the UCM brand, Care Network physicians will not have faculty titles and will not be expected to meet research and publication standards of UC clinical faculty. They will be judged by care and quality performance standards analogous to those applied by UCM's largest and most important health system competitors.

The process has been demanding and educational for Polonsky. In pursuit of the partnership strategy, he has visited many independent community hospitals in metro Chicago. He listened to concerns about partnering with an AHC, for example, that as part of the University of Chicago, they would end up supporting programs unrelated to medicine and patient care.

To allay those concerns, UCM created a new legal entity, the Community Health & Hospitals Division (CHHD) to accommodate partnerships with fully integrated as well as affiliated hospitals. It is governed by a board in which the majority of the members are from UCM, but there is representation from the community partners.

The first member of the CHHD is the Ingalls Health System, located about 25 miles south of Hyde Park, including an acute care hospital and five ambulatory care centers. A full asset merger with the UCM has just been completed.

In other ventures, UCM is pursuing a four-year-old oncology service line comprehensive partnership with Silver Cross Hospital, located to the southwest in Joliet. This joint venture has been very successful and has resulted in a substantial increase in oncology market share for Silver Cross Hospital.

UCM is also preparing to open outpatient centers in the South Loop, located eight miles to the north, and in Orland Park, located nearly 30 miles to the southwest.

For starters, though, Polonsky says, "You have to take care of your home campus and ensure that you run a safe, high-quality hospital with outstanding physicians so that people have a reason to drive past other hospitals to come and see you. This is easy in concept but difficult to implement. If you are not successful in doing this, all of the networks you build will not matter."

UVA Health System: Expanding its footprint[48]

The University of Virginia (UVA) Health System starts with many advantages and assets, says its executive vice president for health affairs Richard P. Shannon. It is part of a public university that is perennially ranked as second-best in the country by *U.S. News & World Report*—behind only Berkeley and on a par with UCLA.

UVA maintains a AAA bond rating (one of only two public universities in the country to be so designated) and an endowment of $8.2 billion—of which $1.1 billion is devoted to the School of Medicine. The medical center has approximately $1 billion cash on hand and runs at a 5% margin.

Additionally, UVA is located in the bucolic mountain town of Charlottesville, where a large percentage of students and residents are so happy they want to stay and practice after finishing their courses of study. But the location is a challenge as well as an opportunity.

Shannon explains that UVA's catchment area is about 600,000 persons in an environment where AHCs such as UVA consistently find that they need 3 million or more covered or attributed lives in order to support their specialty training, research, and clinical services programs. So, notwithstanding its relatively deep pockets and tony campus, UVA has been working on the challenge of expanding its footprint into Northern Virginia and across the commonwealth.

In the past several years, it has met with growing success.

By partnering with community hospitals, UVA has been able to broaden its base for tertiary and quaternary referrals, while bolstering local institutions and helping to meet the goals of community service that being a public, state-supported institution entails. As an additional benefit, it has been able to expand its population base in preparation for payment reform.

Typically, rural community hospitals in Virginia are struggling with a common set of challenges that include their inability to recruit and retain physicians, especially specialists; a high percentage of empty beds; and the economic headwinds of the state's failure to expand Medicaid.

UVA's first move in an expansion strategy aimed at building a "rational system of regional community hospital care" was to acquire and turn around Culpeper Regional Hospital, a rural hospital located about 40 miles from Charlottesville. With an $80 million capital commitment but, as it turned out, no actual investment of funds beyond transaction costs being required, UVA was able to parlay an initial 49% minority share into a 100% ownership position within three years. As part of the turnaround, Culpeper improved rapidly from an ongoing 15% loss of admissions to a positive margin of $2.5 million in fiscal year 2016, with a 15% growth in admissions.

Culpeper quickly became an attractive practice site for recent trainees in obstetrics, orthopaedics, and cardiology, with physicians spending 75% of their time there and 25% in Charlottesville. At the same time, UVA was able to stanch the previous flow of low-acuity patients into its main hospital in Charlottesville by keeping them in Culpeper, freeing needed beds for tertiary and quaternary cases.

And importantly, Culpeper then turned into the opening salient of what became an even bigger and more meaningful deal—the creation of a joint operating company (JOC) with the North-Central Virginia system Novant Health. Both parties brought assets to the table, with UVA's contribution of Culpeper Hospital and a 55% share of the Culpeper Surgery Center being augmented by the equity value attached to UVA's name, valued at 15% of the final terms. As part of the JOC agreement, UVA became a 40% owner of three additional community hospitals in Northern Virginia, in Prince William, Haymarket, and Gainesville.

Novant serves as manager of the JOC, while UVA committed to an academic affiliation agreement providing for research, clinical trials, physician rotations, training programs, and educational sites for residents and students. "By creating the JOC, we not only got the referrals from Novant sites in Northern Virginia, we also got access to their primary care network," says Shannon.

Corporate services provided by the JOC will include a supply chain, EPIC information systems, care protocols, and safety and quality standards.

At the same time, UVA launched a second strategic partnership designed to create a rational system of advanced pediatric services in the commonwealth. UVA Children's Hospital is the leading provider of advanced pediatric transplant services, with the exception of pediatric liver transplant services. Rather than build their own such program, UVA is collaborating with Children's Hospital of Pittsburgh in a program intended to create pediatric liver transplant capacity in Charlottesville over a three-year period. With children dying on the national wait list for liver transplants, UPMC approached UVA with a proposal—they would help stand up a new program at UVA, by sending a liver transplant surgeon and nurse coordinator to Charlottesville to perform cases there with UVA surgeons assisting. UVA agreed to pay an annual fee and 20% of the revenues. This has allowed UVA to perform four cases in the first six months of the program.

"In certain areas, especially in pediatric specialties, you can partner in highly effective ways to create rational systems of care, even in a network that is widely geographically dispersed," says Shannon.

In early November 2016, UVA announced the launch of yet another major partnership, with Inova Health System, which will extend the Charlottesville school's footprint farther into Northern Virginia than ever before. The agreement has several major arms, including the formation of a Global Genomics and Bioinformatics Research Institute at the Inova Center for Personalized Health in the Washington, D.C., suburb of Fairfax County; a cancer research partnership aimed ultimately at achieving NCI Comprehensive Cancer Center designation; and the opening of a School of Medicine campus at Inova, allowing medical students to complete third- and fourth-year clerkships in Northern Virginia.

The School of Medicine will bring UVA partners from the School of Engineering and Applied Sciences and the Darden Business School to create a true cross-disciplinary research and educational experience in the shadow of the nation's capital.

IX. Recommendations and Findings

AHCs have traditionally had an important societal role in performing research to advance the cure

of disease and improvements in public health. They also have had an important traditional role in educating health professionals to provide care to individuals and now to populations of patients, and providing that care in both affiliated and owned hospitals and health systems. These missions of the AHC are carried out in unique ways, depending on specific location and organizational circumstance. While the missions (who AHCs are) remain constant, the vision for each mission (what AHCs do) must adjust to specific environmental circumstances. Each AHC must develop strategies true to the vision tailored to its specific environment. Successful execution of strategy requires an effective organizational structure that addresses how faculty and staff are engaged and treated fairly and how management and support systems are adapted to deploy the strategies. For AHCs in particular, it is critically important to clearly delineate internal organizational, operational, and financial interdependencies of the missions, as well as the parent university, as one contemplates building and participating in clinical networks.

Specific recommendations include the following:

- Protect your AHC's academic mission, first and foremost, as you develop a strategic plan. Remember that the goal is not to run more hospitals; the goal is to meet your missions, and this can only be done if you maintain an active presence and relevance in local and regional clinical markets. If you determine a different size or design is necessary, consider the full range of options that you might pursue, whether growth, acquisitions, mergers, affiliations, joint operating agreements, or any of several other potential approaches. Engage legal counsel early and throughout the process of exploring any planned partnership. In doing strategic planning, seek external perspectives. Include outsiders who can "shoot holes" in your plan. By forcing you to confront uncomfortable realities or needs, they may be doing you the greatest favor. Even if you decide not to make any changes, you must do the assessment. Complacency is not an option. Circumstances change and you may find just a few months later that all the work was well worth it. Plus, you will have broadened your institution's perspective.
- Understand that the right choice for any AHC depends on its role in the local health care delivery system, finances, and cultures. Affiliations in the form of partnerships or joint ventures may make as much sense, or even more so, than mergers or acquisitions. Needs reflect geography, level of competition, market circumstances, local history and culture, and the distinctive mission of each AHC as well as its own finances and culture. If you have seen one market, you have seen one market.
- Bi-directional benefit must be central for a successful partnership. Know what you need and want from your partners, what they need and want from you, and what each can actually provide (both short term—you need simple, quick wins to support buy-in—and long-term). Maintain a two-way perspective. In addition to asking what your AHC can get from others in the form of affiliations or partnerships, ask continually what your AHC can give to others.
- Don't sell yourself short. Recent cases and business analyses (such as Moody's report on academic medical centers and universities)[26] prove the value of the AHC brand and demonstrate the superior business performance of university-affiliated AHCs. Have confidence that the value of your brand is appreciated and coveted by smaller community hospitals, health systems, and physician groups.
- Work hard to see yourself through others' eyes. Understand that independent hospitals, health systems, and physician groups may be suspicious, even fearful, of getting enmeshed in academic politics and possible budget diversions to support academic programs even within the AHC, but particularly within other components of the affiliated university. Approach operations and governance arrangements with this understanding in mind. Begin educating your governance and university leadership about the need for a clear, simple organizational structure that enables community partners to understand how they fit into the AHC and university structure and how timely decisions will be made. These factors must also recognize the difference between the AHC and community health systems to preserve the key benefits the AHC brings to the partnership.
- Expect your analysis of the covered lives needed to support your clinical delivery system to closely parallel the same analysis of covered lives needed for your educational and research programs. Most research intensive AHCs will need millions of covered, attributed, or influenced lives in their networks to accomplish all of their goals.
- Keep in mind that the one thing AHCs do uniquely well is educate health professionals in the context of innovation, research, and highest-quality clinical care. Therefore, a primary consideration in sizing an AHC's clinical delivery system must be assuring a flow of referrals of sufficient complexity to maintain tertiary and quaternary programs.
- Answers may very well vary over time. Your answer now may not be your answer in five years.
- All relevant stakeholders should be kept in mind. Of course, physicians/physician groups and hospitals/clinics must be considered, and neither can be neglected. Community leaders, staff, students, donors, and—most important—patients must be given serious consideration as well. A communication strategy for all of these key groups is required.
- Keep the ultimate ends of managing population health and advancing your social mission in mind. Remember, no margin, no mission. But if the mission fails, margin is irrelevant.

Success in any complex undertaking requires leadership, communications, attending to core values, resilience, and reservoirs of good will. Size in and of itself is not the measure of excellence—innovation, quality, effective management, and wise governance are all essential. A number of our past Blue Ridge reports can offer useful advice relating to each of these important dimensions. All of them are accessible on our website at http://whsc.emory.edu/blueridge/ (see also page 41).

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The Blue Ridge Academic Health Group studies and reports on issues of fundamental importance to improving the health of the nation and our health care system and enhancing the ability of the academic health center (AHC) to sustain progress in health and health care through research—both basic and applied—and health professional education. In 20 previous reports, the Blue Ridge Group has sought to provide guidance to AHCs on a range of critical issues. (See titles, opposite page.)

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The Blue Ridge Academic Health Group seeks to take a societal view of health and health care needs and to identify recommendations for academic health centers (AHCs) to help create greater value for society. The Blue Ridge Group also recommends public policies to enable AHCs to accomplish these ends.

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