Resource Guide:

Alternative Alignment Models for Academic Medical Centers

Alignment Alternatives Overview*

- Healthcare organizations of all types are evaluating their ability to remain independent given the significant changes occurring now and on the horizon.
- As more care becomes concentrated within fewer competitor systems AMCs are seeking ways to protect their market positions.
- Sufficient scale, aligned referral bases and broad geographic reach are essential for achieving market share growth and meeting academic missions.
- Many AMCs are actively seeking ways to respond to these and other emerging imperatives.
- Healthcare providers, including AMCs, are entering into partnerships no one would have anticipated five years ago (e.g. collaborating with proprietary companies such as Duke/LifePoint and CHS and the Cleveland Clinic).
- In addition to alignment with other hospital organizations, AMC's are also re-evaluating their relationships with their clinical faculty and community physicians. Structures including community physicians and clinical faculty are emerging as relationships with both are required under population risk contracts.
- It's imperative for an academic medical center, clinical faculty and practice plan to become a single, integrated, accountable clinical enterprise that is efficient and focused on competing successfully in a highly competitive, price-sensitive environment.
- This document provides a resource guide for AMC leaders. It details various alternative alignment models both with other hospital organizations and systems as well as with faculty and community physicians.
- This document is not intended to include a comprehensive array of all possible transactions or alignment strategies. Traditional transactions have been purposely excluded. The document focuses only on emerging models.

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Key AMC Challenges Related to Market Repositioning

Everybody Knows…	Implication for AMCs
Rapid Provider Consolidation	• Non-AMC providers are gaining the size and strength to drive market dynamics and negotiate on an equal or better footing than AMCs.
Shift Toward Population Risk Contracts	• AMCs which are not well positioned to be the principal contracting entity for population risk contracts are likely to become "commodity" providers to others who are.
Reductions in Provider Payments	• Payments of all types are expected to decline including federal reimbursement (e.g. Medicare, DSH payments) and commercial rates; AMC cost structures (10-20% higher than competitors) are not sustainable.
Value-Based Payment Structures	• Payers and purchasers of care are less willing to pay a premium for patients to receive care at AMCs; AMCs must effectively compete on a cost basis for the majority of care that others also provide at acceptable levels.
Threats to Clinical Medical Education Funding	• There is no comprehensive policy for financing clinical medical education. The academic portion of the AMC cost structure and historical clinical education funding sources face significant downward pressure.
Multiple Missions of the Academic Organization	• AMCs need to find ways to reconcile mission commitments with changing economic realities and compete with community providers with only clinical missions, clearer hierarchical structures and often quicker decision-making.

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Other Less Recognized Challenges for Consideration

Other Challenges…	Implication for AMCs
Long-Standing Tradition of Concentrated Clinical Education	• Concentrating clinical education within limited inpatient and outpatient sites will be called into question by forces driving down inpatient utilization and shifting care to distributed outpatient settings.
Changing Economic Incentives Impacting Referral Decisions	• As providers assume risk for the cost of care, their referral decisions will no longer be purely clinical, detached from economic factors.
Outdated Academic Affiliation Agreements	• Many Academic Affiliation Agreements between clinical faculty and their primary teaching hospitals are outdated. These long term agreements did not anticipate the principles of population health or risk.
Emerging Clinical Science Limited by Cost Pressures	• With downward pressure on costs, it will be more difficult to introduce emerging science and technology without a strong economic value proposition.
Investments at Odds With Utilization Trends	• AMCs' substantial investments in single site inpatient and outpatient complexes are at odds with the negative trend line in inpatient utilization and access expectations.

AMCs will need to utilize <u>Alternative Alignment Models</u> to address these challenges and strategically reposition the organization

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*Alternative Alignment Models **without** Corporate Change of Control to Strategically Reposition AMCs*

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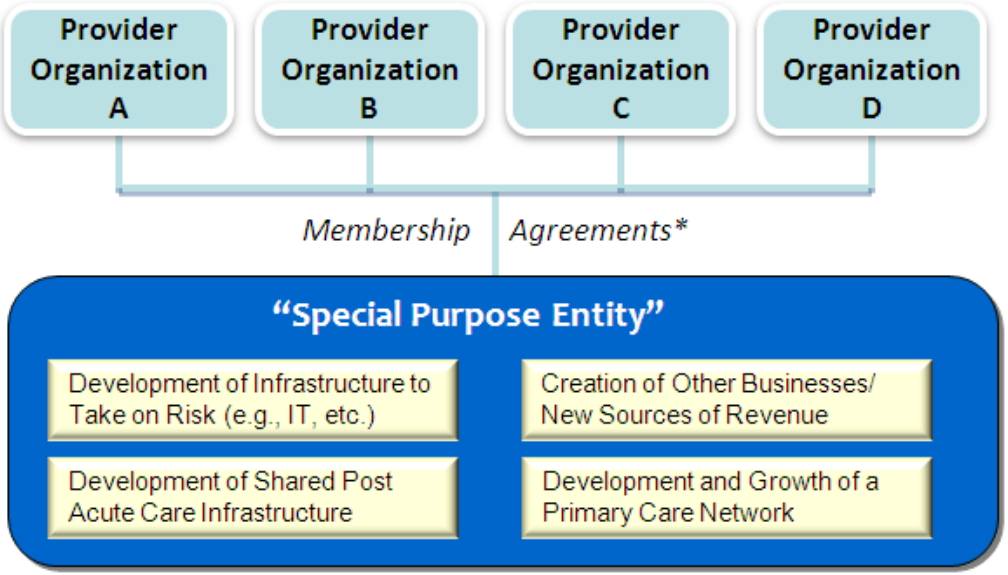
Special Purpose Entity

Develop a Special Purpose Entity that would have its founding members create a new non-profit entity for select joint activities. In some places called a "Shared Services Arrangement" or "Common Infrastructure Organization".



- Membership Agreements define the scope of purpose of the work done together.
- Members move a large portion of their cost structure into the "Special Purpose Entity" (SPE).
- Members remain independent and retain their own assets/liabilities and control over their delivery systems.
- The SPE serves as a platform for the parties to develop broader shared activities over time.
- It creates the circumstances for them to engage in new business activities they couldn't do on their own.

Special Purpose Entity Examples

Purchasing Collaboratives

- Multiple parties enter into contractual agreements (purchasing collaboratives) that create a new entity to achieve greater efficiencies and economies of scale in purchasing arrangements.
- Partnering systems are controlling members of the collaborative but ownership and governance of their other operations remain independent.
- ***Example***:
  - **MNS Supply Chain Network** is a partnership between MedStar Health (**Georgetown University Hospital**) in Columbia, MD, Novant Health in Winston-Salem, NC, and Sentara Healthcare in Norfolk, VA
  - Designed to lower costs of medical supplies and services formed in 2011
  - Governed by a board which includes a senior executive from each of the 3 systems with the board chair rotating annually among the three systems.

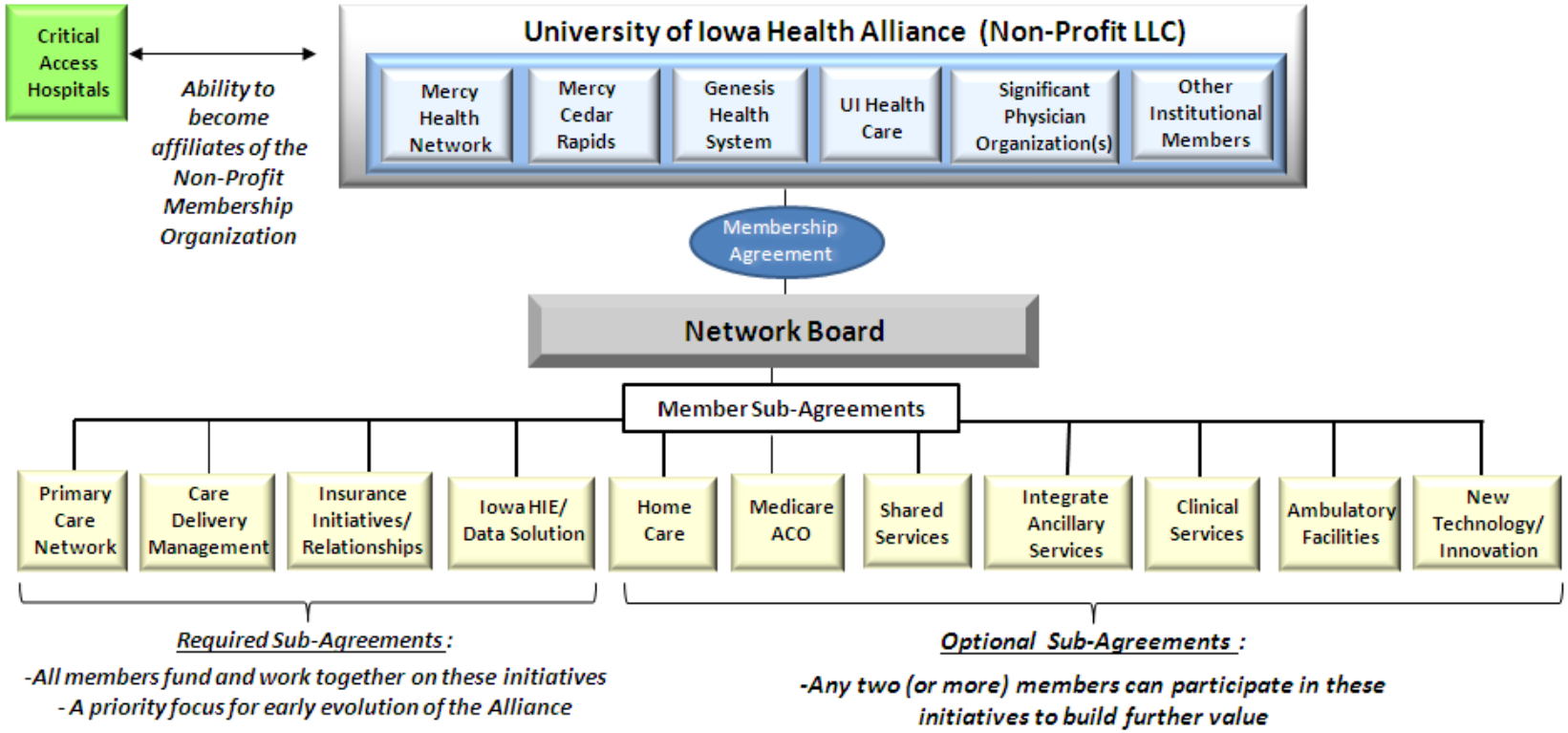
Best Practice Collaborations

- Allow partner organizations to work together to identify, define and implement best practices for clinical and business operations
- Require little to no capital investment to establish
- Can be structured to allow additional entrants into partnership
- ***Example:***
  - **BJC Collaborative** formed in 2012 between **BJC Healthcare** in St. Louis, St. Luke's Health System in MO, CoxHealth in MO, Memorial Health System in IL
  - It is a non-profit LLC managed by operating committees with leadership from partners
  - 4 roundtable groups share best practice information on patient care, employee benefits, professional development and regulatory compliance

Integration without Merger

- Integration without Merger is earning its place as a preferred strategy among providers nationwide *unable* to or *uninterested* in pursuing a full sale/asset merger.
- Hospitals and smaller health systems are joining together on a *selective basis* to achieve substantial, mutual benefits while maintaining fundamental autonomy.
- The resulting relationships range in intensity, purpose and scope depending on the unique circumstances of the hospitals involved.
- While aligning with one hospital/system is often more efficient and practical, multiple parties may be required to achieve the size and scale needed for long-term success.
  - Involving multiple parties can occur at the outset or incrementally over time, as an initial two-way relationship can create a story or value proposition to attract others later on.
  - Providers need *not* be geographically contiguous to pursue Integration without Merger and derive substantial benefits; certain functions can be combined and accomplished remotely.
- These arrangements could ultimately be a prelude to merger if it eventually makes sense.

Integration without Merger Example: University of Iowa Health Alliance



Three community systems were working together on population health and a commonly funded HIE data solution.

University of Iowa Health Care was working separately on strategic positioning in its market and saw a need to align.

The four parties came together and negotiated a corporate Membership Agreement to form an alliance.

The Agreement defined how the parties would work together as a Network Board and established that members would enter into sub-agreements of two types: (1) Required and (2) Optional.

Members built within the Agreement the ability to grow by adding other members over time.

The Alliance also has the ability to establish affiliate relationships with Critical Access Hospitals as appropriate.

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Integration without Merger/Statewide Collaboration Example: Health Innovations Ohio (HIO)

- ✓ **Created a statewide collaboration** with 4 Ohio Health Systems: **University Hospitals of Cleveland**, Summa Health System in Akron, Mount Carmel Health System in Columbus, Catholic Health Partners (CHP) in Cincinnati
- ✓ No assets were combined between the 4 parties. However, within this structure there is a fractional ownership between CHP and Summa Health. CHP bought a 30% share in Summa for $250M to provide capital to the organization
- ✓ HIO hired a dedicated executive to drive the business agenda and created infrastructure to support the organization
- ✓ HIO members lead Ohio in piloting and establishing new models of integrated care to reduce fragmentation and deliver improved quality, patient experience and cost.
- ✓ They have launched more than 60 Patient-Centered Medical Home Sites, recognized by the National Committee for Quality Assurance. They also have created Accountable Care Organizations to manage the health of a variety of populations, enrolling nearly 200,000 traditional Medicare beneficiaries, pediatric Medicaid recipients and HIO member employees.
- ✓ The new organization will focus initially on three areas:

1. **Senior Health** – In January, HIO expanded access statewide to two Medicare Advantage plans offered by its health systems – SummaCare
2. **Medicaid** – The 4 health systems plan to share strategies for cutting the cost of delivering care to high risk patients, expanding coverage to more patients in the state, and improving outcomes of patients on the government's health plan for families and children with low income
3. **Population Health Management for Employees** – The 4 health systems have a combined 70,000 employees, and HIO will focus on comparing wellness programs of each system to find the best ways to keep those employees and their dependents healthy

Collaboration with Proprietary Hospital Operator

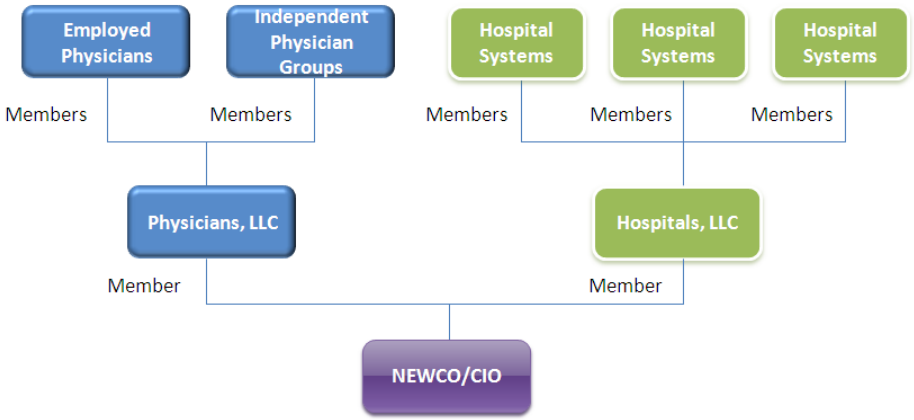
Healthcare reform is creating new relationships between providers that would not have occurred historically as they prepare for new demands in an era of lower reimbursements.

- ✓ One example is the ***Cleveland Clinic*** and investor-owned Community Health Systems (CHS) who announced the formation of a "strategic alliance" this past March in which:
  - ✓ Both organizations will remain independent but ***formed joint advisory groups*** to consider improvement in areas such as clinical services, physician alignment and integration, supply chain processes, other hospital operations, developing standardized data to share, and developing a strategy for national employers.
- ✓ Initially the purpose of forming this alliance is to reduce costs through operational efficiencies and improve care within both health systems
- ✓ Benefits to both organizations include:
  - ✓ **Cleveland Clinic:** Benefits from CHS's expertise in hospital operations and efficiencies and access to CHS's wider referral base
  - ✓ **CHS:** Obtains access to better processes and an association with the Cleveland Clinic brand

Faculty/Physician Alignment:
Inclusive Accountable Care Organization:

- This model is designed to accommodate employed and independent physicians, as well as owned and independent hospitals in a clinically integrated organization that has a unique governance structure and focuses on risk contracting, including total cost of care risk contracts, a unique "two pool" internal finance mechanism between the physicians (both primary care and specialists) and the hospitals, as well as a comprehensive system of population management.

Inclusive Accountable Care Organizational Structure



- This was developed and implemented at **Beth Israel Deaconess Care Organization (BIDCO)**, formerly known as Beth Israel Deaconess Physician Organization, in Boston, Massachusetts. It was developed with multiple systems including BIDCO hospitals and providers, Cambridge Health Alliance and Signature Healthcare
- The model was created to:
  - Align member hospital and physician efforts to improve patient care and care management
  - To share risk under reimbursement contracts
  - To effectively compete with Partners HealthCare and other large complex organizations

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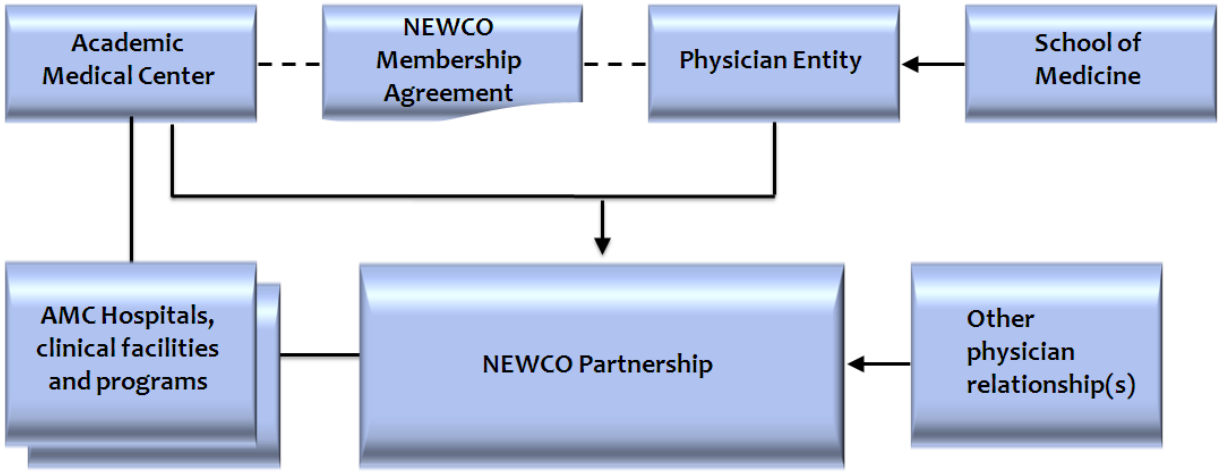
Faculty/Physician Alignment: "Dual Member" Faculty Practice Model

Purpose of Creating "Dual Member" Faculty Practice Model: Provide the structure for all clinical faculty within a school of medicine and all the employed clinical faculty of the related primary teaching hospital to reside within one organization in order to:

- ❑ Create a unified practice organization
- ❑ Create essential structure for Health Reform
- ❑ Improve the competitive position of both the AMC and the faculty practice
- ❑ Create a common brand for the AMC and faculty practice
- ❑ Improve commercial insurance relationships
- ❑ Create governance alignment
- ❑ Create economic alignment

- ❑ Create effective leadership for all 3 missions
- ❑ Mitigate regulatory limitations
- ❑ Increase total dollars in the enterprise
- ❑ Eliminate unproductive transactional effort
- ❑ Create an organization attractive to new faculty & private practice physicians

Faculty/Physician Alignment: "Dual Member" Faculty Practice Model



- Newco Partnership is established as a "dual member" Limited Liability Company (LLC) .
- The primary foundational document is a "Master Affiliation Agreement" with various critical sub agreements (e.g. Operating Agreement, etc) between its two Members.
- The Operating Agreement will delineate all of the aspects of individual Member rights and responsibilities for the governance, mission, organization, operations and finance of University Physicians.
- The legal structure and the Master Affiliation Agreement will replace substantial portions or all of the existing "AAA" agreement between the Members.

*Alternative Alignment Models **with** Corporate Change of Control to Strategically Reposition AMCs*

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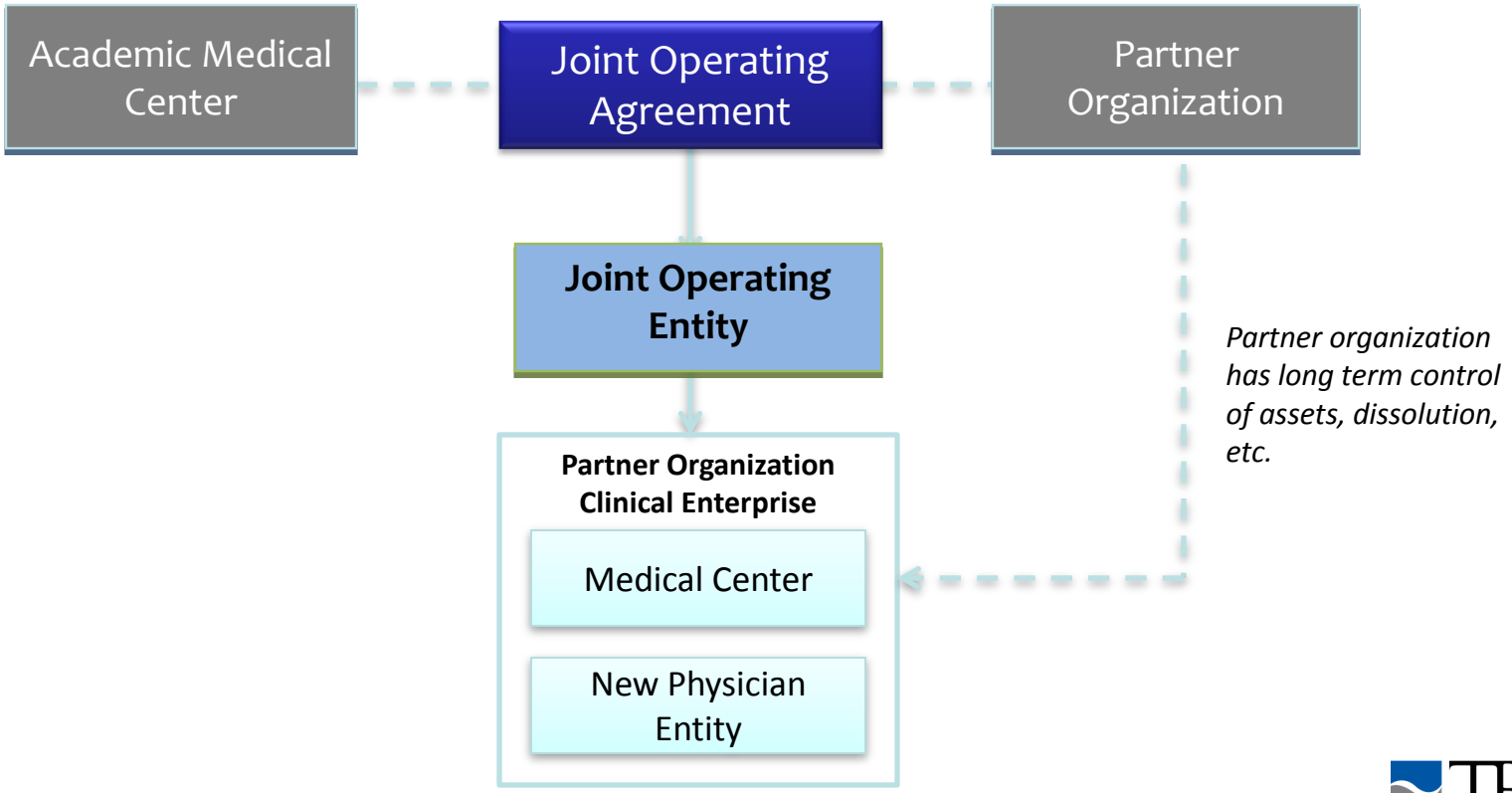
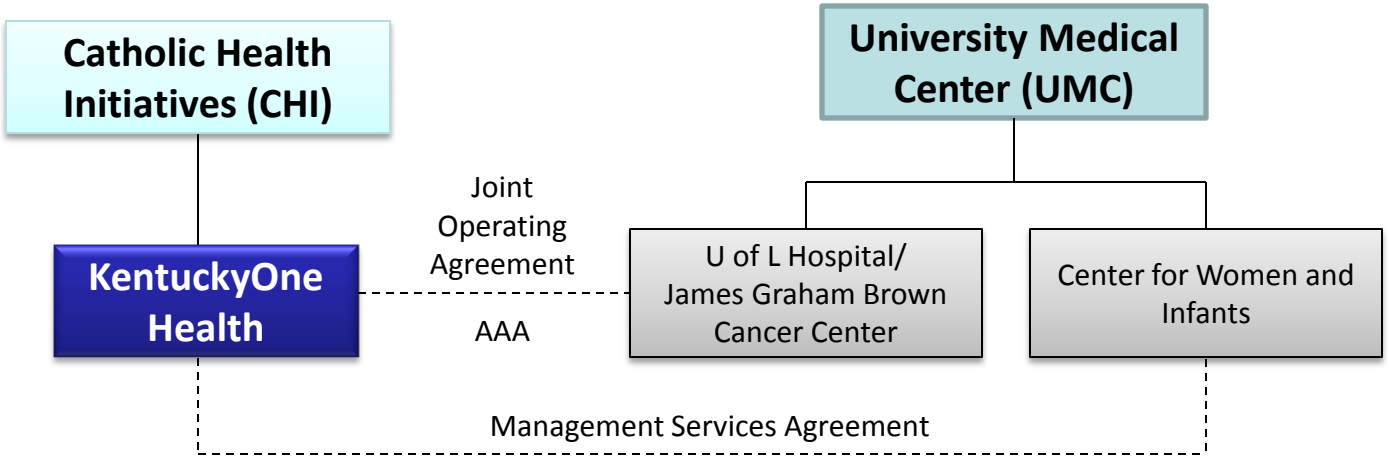
Joint Operating Agreement (JOA)

Partnering organizations retain separate identities and a certain amount of autonomy. Considerable management and financial authority is shifted to the joint operating entity for the operation of the partner organization. The relationship between the AMC and the partner organization is predicated on the value the AMC brings and not necessarily on capital contributed by the AMC. The relationship returns economic value to both parties. Terms of an agreement govern their coordinated operation. The model is adaptable to apply to single organizations or combined operations of multiple providers.



Joint Operating Agreement Example: U of L Hospital and KentuckyOne Health



- UMC retains ownership of its assets and KentuckyOne oversees operations, except for the Center for Women and Infants which UMC will control.
- The current board remains intact and managerial control will stay local
- Provides structure for relationship with a Catholic owned partner (CHI) – none of the directives of Catholic Church are applied to any of the University's facilities.
- Partnership also provides necessary support for academic mission of UofL to train doctors, nurses and caregivers as well as for research
- CEO of U of L Hospital and CEO of KentuckyOne control how investments of by KentuckyOne
- KentuckyOne invests $543M in UofL Hospital over first 5 years. That could increase to over $1.4B over 20 years

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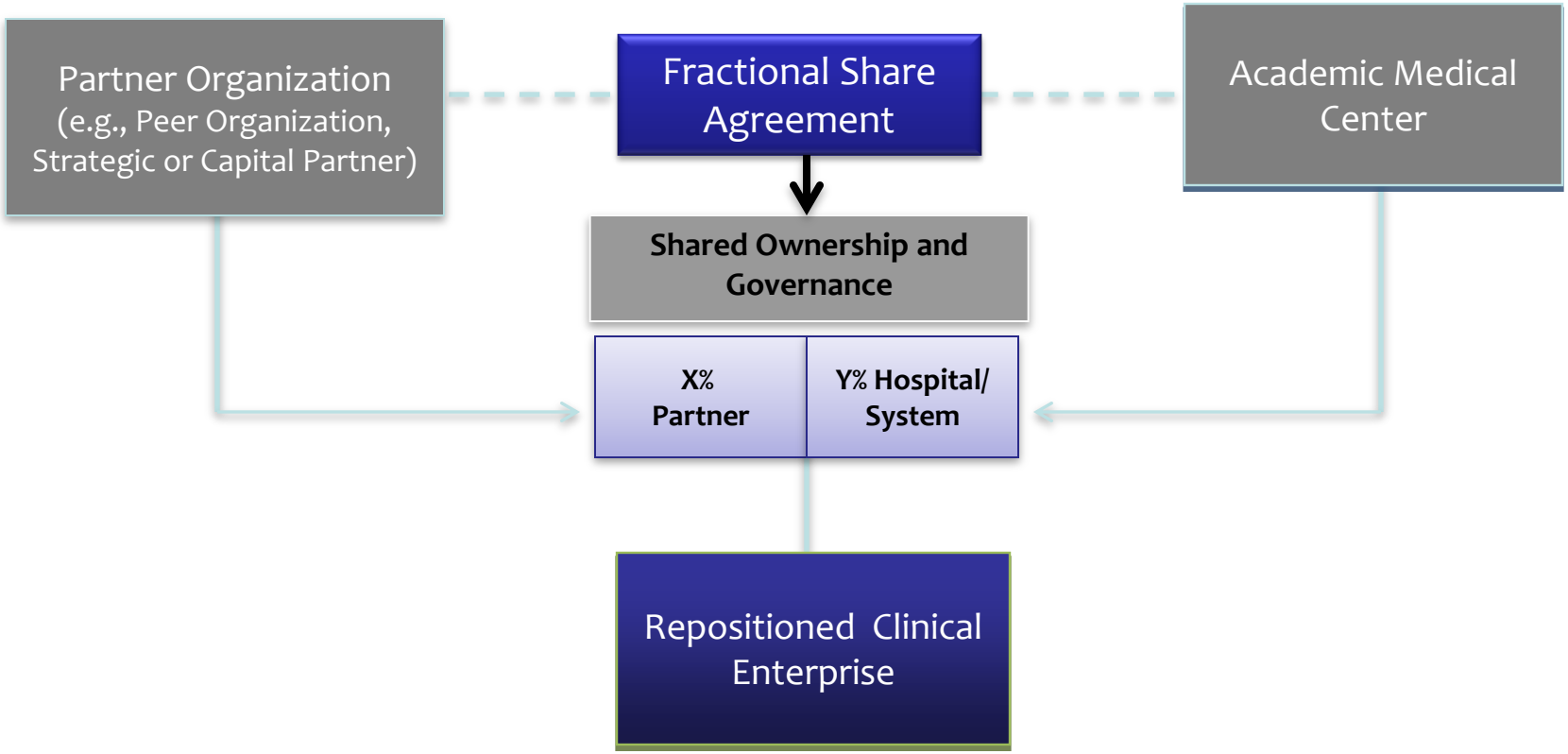
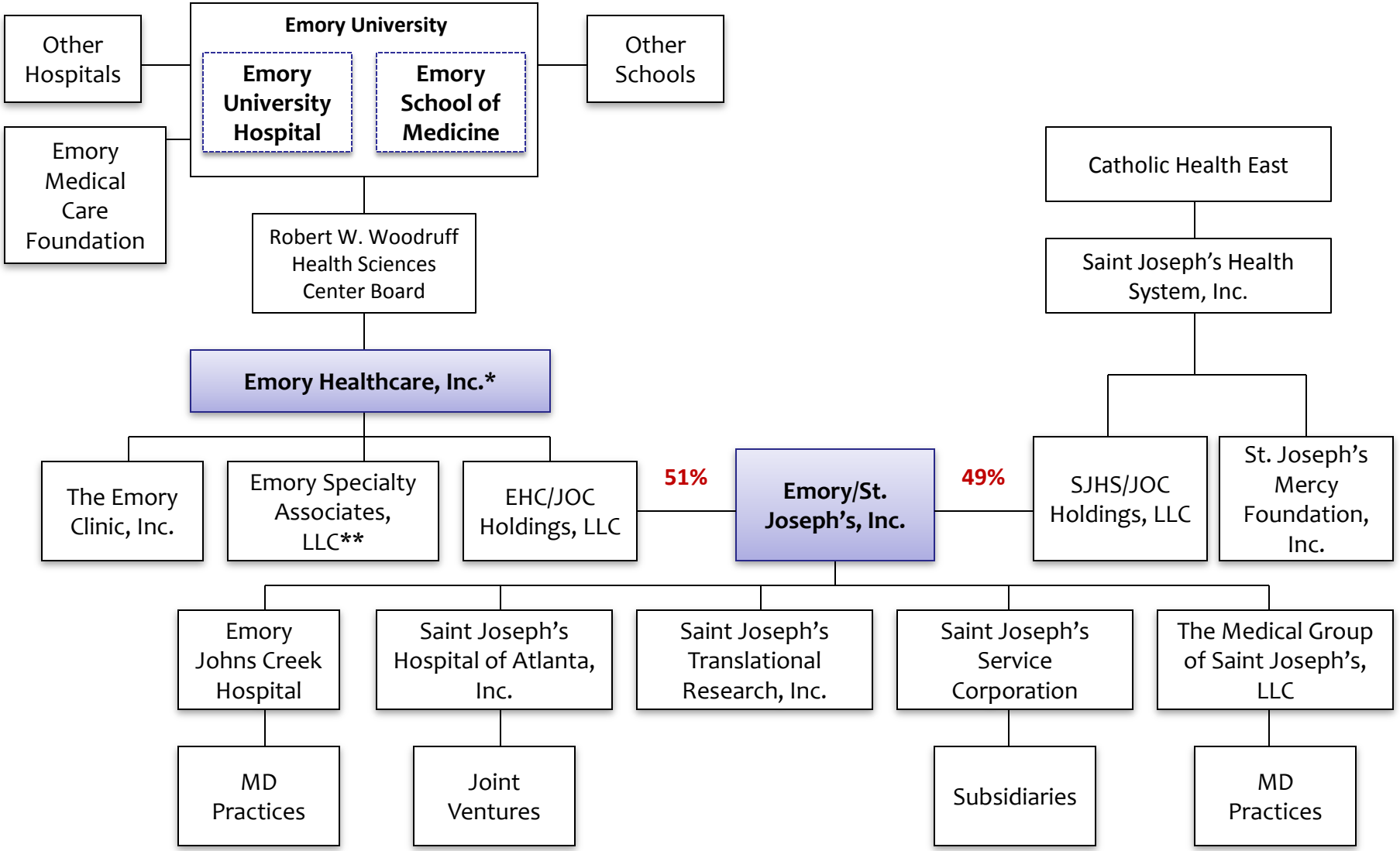
Fractional Ownership Model (Majority/Minority)

A "Fractional Share Agreement" may be for a minority, equal or majority share. The partner organization provides capital and other commitments in exchange for its share of ownership and governance rights/authorities of the Clinical Enterprise. The governance agreement addresses the respective control interests of both parties.



Fractional Ownership Example: Emory University - *Structure*



*Emory Healthcare, Inc. provides comprehensive management services to Emory/Saint Joseph's, Inc. and all operating subsidiaries

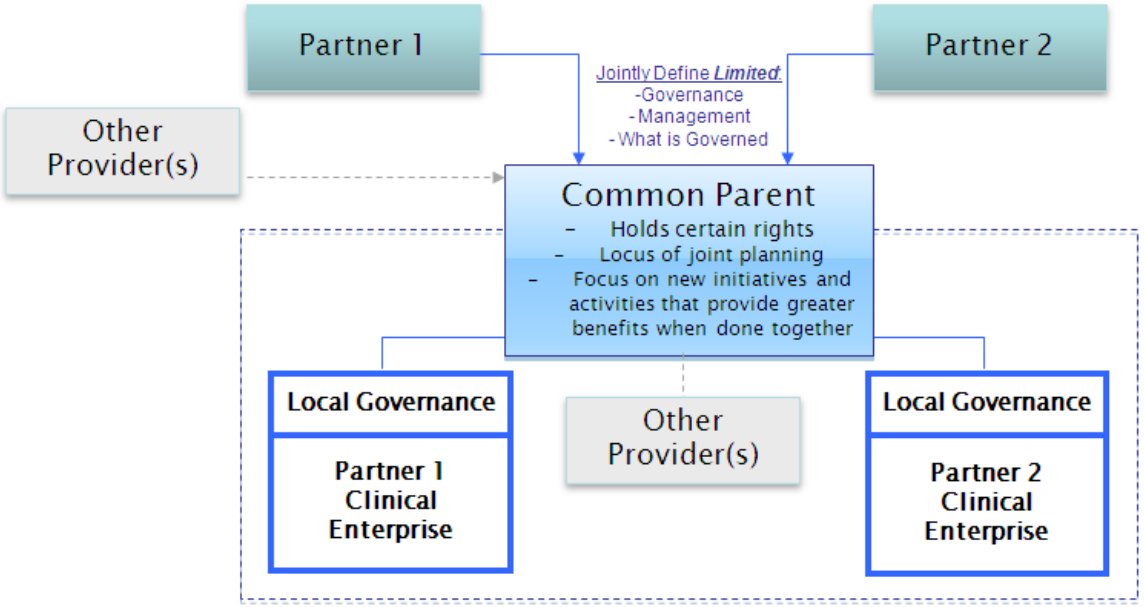
**Emory Specialty Associates, LLC employs all employed physicians of Emory/Saint Joseph's, Inc. and all operating subsidiaries

Fractional Ownership Example: Emory University

- Relationship between the University and Health Sciences:
  - The relationship between the University, the Emory Hospitals, and Emory School of Medicine remains unchanged: the Hospitals and School of Medicine are operating units of the University
  - University sub-committee (Woodruff Health Sciences Center Board) governs health sciences operations
  - Emory Healthcare is clinical enterprise; separate 501(c) (3) but ultimately governed by University
  - Three governing "boards"
  - Affiliation involves a subset of Emory Healthcare operations
- Relationship with marketplace:
  - Joint Operating Company is the new entity, with EHC as majority owner
  - Tax-exempt status (EHC group exemption)
  - EHC managed
- Application of Ethical and Religious Directives of the Catholic Church:
  - Saint Joseph's remains a Catholic institution
  - Emory Johns Creek Hospital does not become a Catholic institution but will operate in a manner consistent with the ERD's as applicable to a secular institution
  - SJHS appoints Values Integration Committee and Sr. VP of Mission to oversee Catholic mission-related matters and application of ERDs to all JOC facilities

Creation of a Common Parent

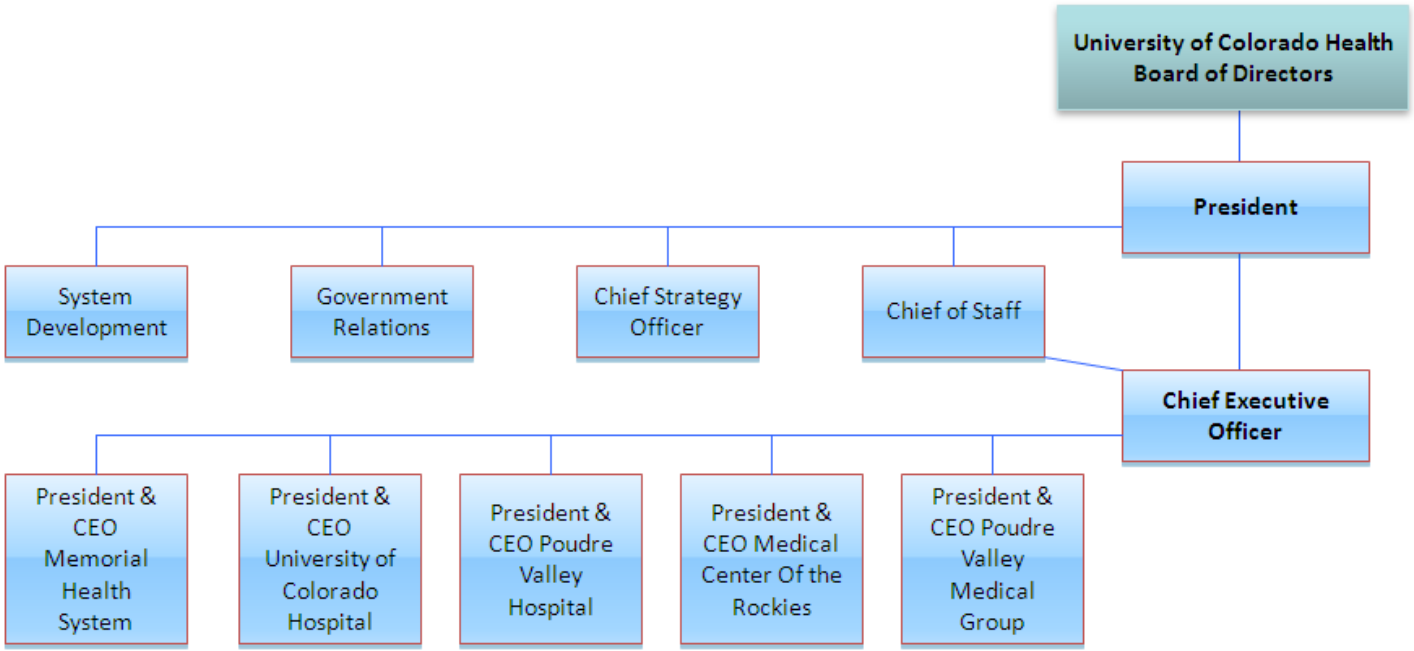
A common parent organization is created to bring two or more parties together under a single structure that they jointly define. Participants continue to have local boards and assets are kept separate but many of their operations that can be improved by working together are combined.



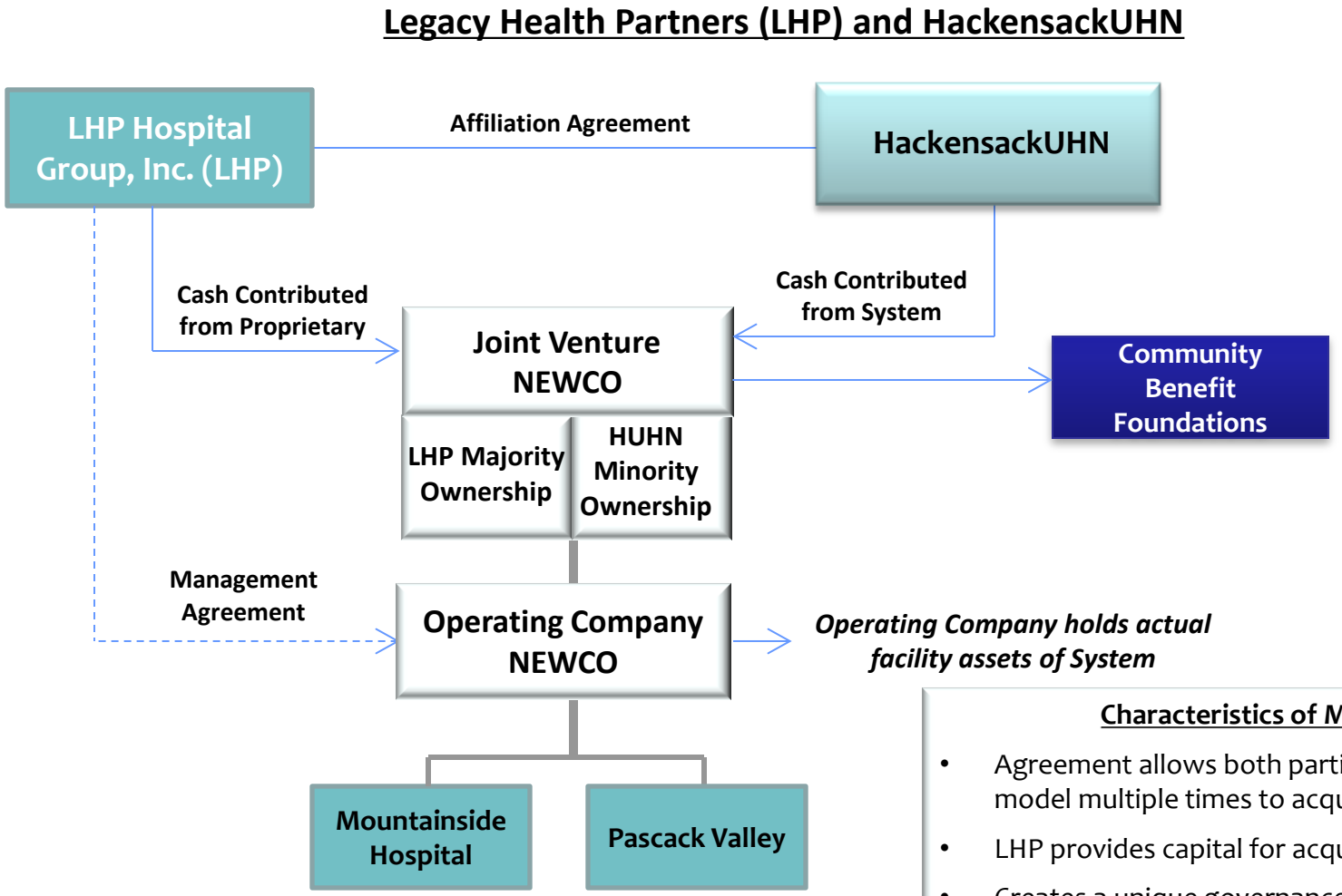
- Common Parent serves as vehicle to collaborate on activities that return greater benefits when done together.
- Members cede certain rights for potential shared benefits (e.g., better terms via single signature contracting)
- Common Parent would lead creation of other initiatives between the parties with broader powers over time.
- Helps to establish a broader value proposition to attract other potential partners.
- Through the common parent the parties could engage in collective consolidations (e.g., buy a hospital, etc.).

Creation of a Common Parent Example: University of Colorado Health - *Structure*

- Merger-like in many respects: shared bottom line and a central board of directors
- Each hospital continues to exist as a separate entity and controls operations at respective facilities
- Integration of central services, i.e., IT, Finance, Human Resources, Marketing, Legal
- Integrated leadership structure governs strategy formulation
- Joint management of clinical operations and concurrence on leadership appointments and managed care contracting
- Joint fiduciary responsibility for cost-effectiveness and efficiency of clinical delivery systems



Consolidation of Hospitals with Proprietary: Joint Venture Between LHP and HUHN



Characteristics of Model:

- Agreement allows both parties to use this model multiple times to acquire other hospitals
- LHP provides capital for acquisitions
- Creates a unique governance model
- Entities can take risk together

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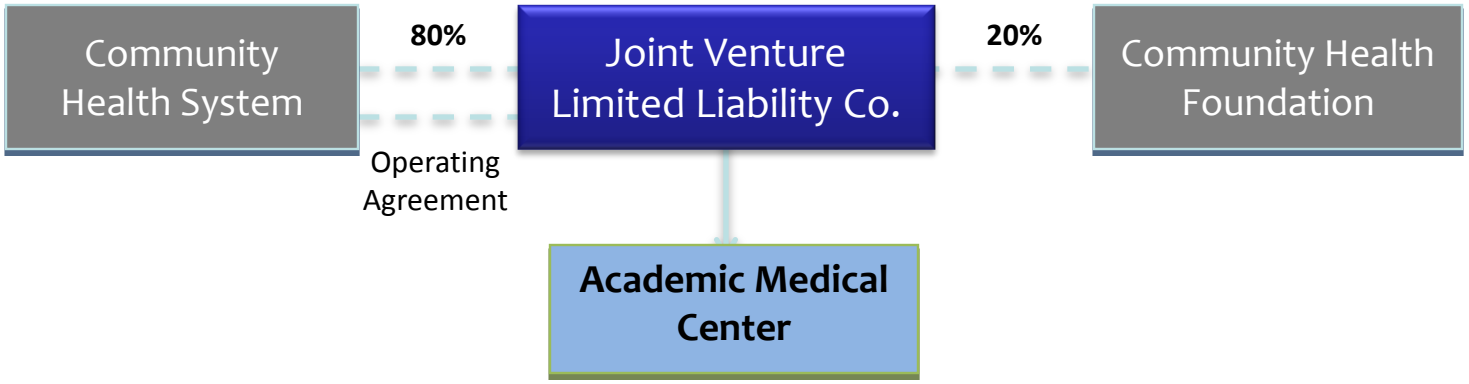
Consolidation of Hospitals with Proprietary: Community Health Systems Joint Venture LLC



- Academic Medical Center sells 80% membership interest in the LLC to CHS
- Community Foundation established which owns remaining 20% interest in the LLC
- LLC governed by Operating Agreement and governed by a Board of Directors comprised of equal members from CHS and AMC
- All actions taken by Board would be accomplished through “block voting” and would require a majority of each organizations appointed Board members
- AMC governance comprised of a local board of trustees of up to 12 members, majority with CHS
- The LLC would enter into a management agreement with CHS where CHS would be responsible for the day to day operations of the LLC and Facilities

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Consolidation of Hospitals with Proprietary: Joint Venture Between Duke and LifePoint

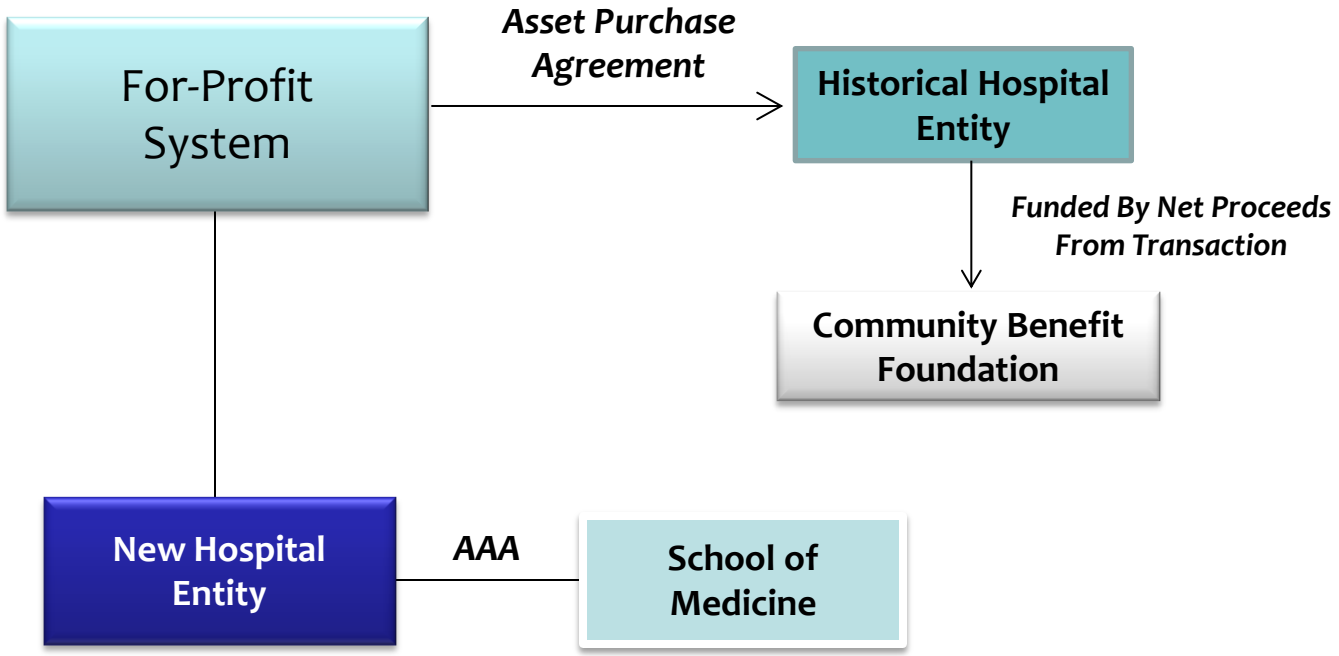
- ✓ LifePoint partnered with Duke University Health System to create a unique **joint venture, Duke LifePoint Healthcare** to own and operate a system of hospitals
- ✓ Both hospitals share an interest in collaborating with hospitals, physicians and patients to bring quality, innovative healthcare services to communities
- ✓ Duke LifePoint Healthcare pursues acquisitions and shared ownership and governance of community hospitals that are looking to become part of a stable, well funded system.
- ✓ Both organizations and related hospitals benefit:
  - ✓ **Duke** offers Duke LifePoint Healthcare's hospitals clinical and quality guidance as well as access to highly specialized medical services
  - ✓ **LifePoint** provides a range of management, financial and operational resources, including access to capital for ongoing investments in new technology and facility renovations
  - ✓ **Hospitals in System** are able to share best practices with hospitals, clinics and healthcare providers throughout the Duke and LifePoint systems and have access to capital
- ✓ Duke LifePoint Healthcare offer hospitals a variety of options to enter the system from acquisition to shared ownership and governance agreements to joint ventures with medical facilities and health providers

Consolidation of Hospitals with Proprietary: Cleveland Clinic and Community Health Systems

- ✓ CHS and the Cleveland Clinic have ***formed a limited-liability company*** to acquire other hospitals, bringing together clinical expertise, capital resources, operational experience and innovation.
- ✓ Pending deals include:
  - ✓ 474 bed Akron General Medical Center (Ohio)
  - ✓ 38 bed Edwin Shaw Rehabilitation Hospital (Ohio)
  - ✓ 25 bed Lodi Community Hospital (Ohio)
  - ✓ Metro Health in Michigan - gives each system their first foothold in the market.
- ✓ CHS creates a separate corporation in each state they own hospitals:
  - ✓ CHS is the controlling member.
  - ✓ Cleveland Clinic has a minority share in each hospital they acquire together.
  - ✓ The Cleveland Clinic has a minority share in exchange for certain services including support for development of clinical services and physician relationships and branding.

Full Asset Acquisition by Proprietary

Acquired organization converts to a for-profit. A Community Benefit Foundation is established. The. An organization (e.g. Foundation) is established to enforce the Purchase Agreement. A local Advisory Board is created with certain responsibilities and authorities. A new AAA is negotiated between the SOM and for-profit system.



Full Asset Acquisition by For-Profit Example: Detroit Medical Center and Vanguard/Tenet

- ✓ In 2010 Vanguard Health Systems, Inc. and the Detroit Medical Center (DMC) completed the final purchase agreement where Vanguard acquired all the assets of DMC for approximately $365M in cash and they assumed all of DMC's liabilities
- ✓ Vanguard agreed to:
  - ✓ Keep all DMC hospitals open for at least 10 years
  - ✓ Invest an estimated $350M for routine capital improvements
  - ✓ Invest $500M on specific capital projects during the first 5 years of ownership
  - ✓ Assume liability for the defined pension plan for DMC retirees
  - ✓ Keep in place a policy for charity, indigent and uncompensated care that is at least equivalent to DMC's current policy
  - ✓ Fully support DMC's education mission and honor all educational contracts
  - ✓ Support DMC's research mission
  - ✓ Maintain DMC's regional headquarters in Detroit
- ✓ Tenet Healthcare recently completed transaction to acquire Vanguard for $1.8B