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GUIDE TO HEALTH CARE PARTNERSHIPS
FOR POPULATION HEALTH MANAGEMENT AND VALUE-BASED CARE

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EXECUTIVE SUMMARY

As the business model for U.S. health care transforms from a volume-driven model to a consumer-centric, value-driven model, new competencies are required of hospitals and health systems to effectively manage a population's health over the continuum of care needs, or a portion thereof. Many hospitals and health systems will need to partner with other organizations to gain the capabilities and efficiencies required to provide services under new care delivery and payment arrangements.

As might be expected, partnerships are proliferating nationwide, with a wide range in arrangement types spanning from less-integrated contractual affiliations to highly integrated agreements.

Developed for hospitals, health systems, and other health care organizations, *Guide to Health Care Partnerships for Population Health Management and Value-based Care* is intended to help executive management and board teams understand key considerations for delivery system and health plan-related partnerships for population health management; partnership types; and the process recommended for partnership exploration and decision making.

To meet these objectives, this guide is organized around three sections:

» *Key considerations in partnering for population health management*
This section addresses seven considerations, including: strategic intent, namely what the organization wants to achieve and how its success will be measured; network development—i.e., the delivery elements that will be included within the partnership's scope; responsibility for population health management (PHM) functions; health plan operations and risk, involving contracting arrangements, insurance license and health plan capabilities; responsibility for product development and management; economic integration and the level of risk to be assumed; and assets to be contributed to the venture and terms of exit provisions.

» *Partnerships that could be considered*
This section describes seven named partnership arrangements in various areas of the country, ranging from highly integrated partnerships to looser affiliation options. Partnership objectives and early initiatives are described, as available, using publicly accessible information.

» *Process recommended for evaluating potential partnerships*
Because achieving a best-fit partnership is more critical than ever for effective population health management, this section outlines an approach that can direct organizational resources to the most promising option(s) using strategic-financial assessment and planning. The approach includes a pre-partnership phase, which covers service area assessment, organizational position assessment, development and testing of baseline projections for the partnership, and evaluation of strategic options. The second phase, which covers making and executing the strategic partnership decision, has five activities, including establishing partnership objectives, identifying and comparing options, selecting the likely best-fit partner and partnership structure, and executing the agreement and transition plans.

Partnerships are accelerating as participants in health care ready themselves for a value-based, population health-focused delivery system. This guide concludes with a description of the characteristics of successful strategic partnerships.

Outside this publication's scope are the many types of hospital-community partnerships with public health departments, chambers of commerce, community health centers, schools, social service agencies, city and county governments, faith-based entities, YMCA/YWCA and other entities to improve community health and build a culture of health. These partnerships are important and should be considered, along with the types of partnerships described in this guide, as an integral part of an organization's population health strategy. Resources such as *Leadership Toolkit for Redefining the H: Engaging Trustees and Communities*[1], *Approaches to Population Health in 2015: A National Survey of Hospitals*,[2] and *Hospital-based Strategies for Creating a Culture of Health*[3] address hospital-community partnerships in detail and are available through hpoe.org.

The legal, taxation and regulatory issues surrounding partnerships are complex and subject to change. This guide does not provide information in these areas; providers should seek expert counsel.

INTRODUCTION

A New Business Model for Health Care

The business model for U.S. health care is transforming from a volume-driven model to a consumer-centric, value-driven model.[4] The value-based care model's objective is to improve quality, access and outcomes, while reducing costs through the effective management of a population's health over the continuum of its health and health care needs.

"Anywhere care" is the new modus operandi for nonacute, low-intensity services. Such care will occur primarily in ambulatory or home settings through in-person or virtual means—whichever best meets the consumer's needs and goals.

To manage a population's health, new competencies are required of hospitals and health systems, including clinical integration; consumer, clinical and business intelligence; operational efficiency; customer engagement; and efficient network development (see Sidebar 1). According to a recent national survey by the Health Research & Educational Trust,[5] more than 90 percent of responding hospitals agree or strongly agree that population health is aligned with their mission. However, the survey also indicates that only 19 percent of responding hospitals believe that they have the financial resources available for population health.

Many hospitals and health systems will need to partner with other organizations to gain the capabilities and efficiencies required to provide services under new care delivery and payment arrangements. Their focus with population health management will be extended to the full or defined portion of the provider care continuum (see Figure 1). Additionally, partnerships with public and community agencies likely will be needed to address and improve the nonmedical social, economic and environmental factors that influence health status at the population level in the nation's communities.[6]

As always, financial integrity continues to matter significantly, differentiating organizations that can afford to assume higher levels of risk through partnership arrangements that meet the needs of growing patient populations.

Increasing Partnership Activity

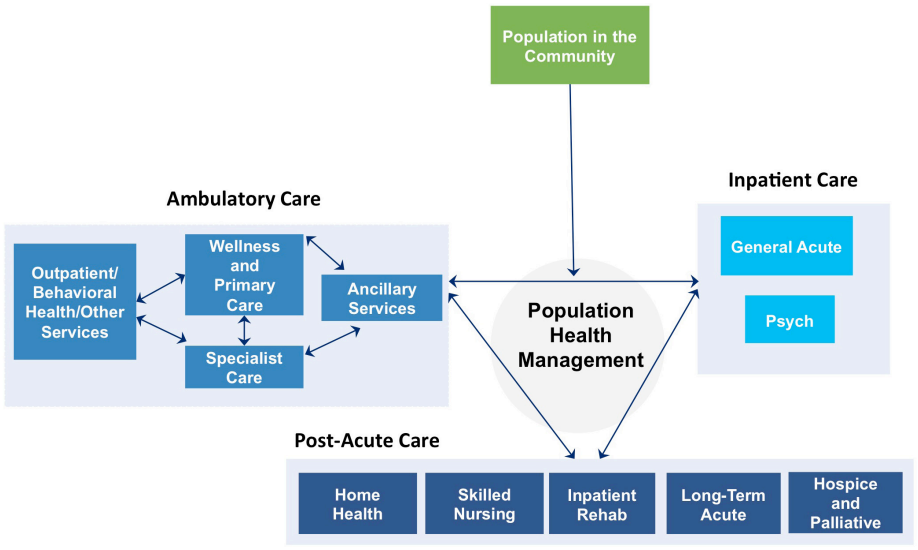
Due to the cost and time required to develop population health management capabilities on their own, many hospitals and health systems are establishing collaborative partnerships and affiliations with providers, health plans and other organizations to gain the needed expertise and scope. As a result, both traditional and nontraditional partnerships are proliferating nationwide. The wide range in arrangement types spans from less integrated contractual affiliations to highly integrated asset purchases. Stakeholder lines continue to blur. The arrangements may be between:

- Traditional providers: for profit, not-for-profit, public hospitals, academic health centers, Catholic or children's hospitals, rural or community hospitals, large physician groups and large health systems
- Other stakeholders: payers, employers, retailers, technology firms and other entities

Additionally, partnerships increased across the broader health care industry, including insurers, retail pharmacies and clinics, biotech companies, device manufacturers and others.

Among hospitals and health systems, announced provider-provider transactions nearly doubled from 2007 to 2015.[7] Additionally, the percentage of announced nontraditional partnership transactions, such as management services agreements, joint operating agreements, joint ventures and minority investments, among others, rose to 16 percent in 2015, up from 7 percent in 2007.

Figure 1. Provider Care Continuum for Population Health Management



Source: Kaufman, Hall & Associates, LLC

Additionally, although not in this publication's scope, hospitals and health systems are increasingly collaborating with community partners to expand their scope of services to address nonmedical factors that influence health status, including obesity, preventive and screening services, access to care, behavioral health, substance abuse and tobacco addiction. A recent survey by the Association for Community Health Improvement and the American Hospital Association revealed that more than three-fourths of surveyed hospitals had partnerships with school districts and local public health departments.[8]

With hospital-hospital partnerships, the latest HealthLeaders survey indicates that 38 percent of responding hospitals were recently involved with partnership activity, while 34 percent were involved with an acquisition of one organization by another, and 10 percent with a combining of two organizations into one.[9]

During the past decades, many provider partnerships have been traditional arrangements. These transactions often were driven by the needs of a smaller organization, which required the help of a partner to improve its clinical programs and facilities.

For many organizations, the rationale for partnership is now moving toward a longer-term strategy for meeting consumer/patient needs under a value-based care delivery model. Many drivers now center on gaining the core competencies required to manage population health, as described fully in Sidebar 1.

As organizations partner with other organizations, benefits to patients and efficiencies can be achieved through:

- Centralization of functions such as IT, purchasing and human resources
- Rightsiting or rightsizing service and resource distribution across the service area
- Process re-engineering, clinical variation reduction and increased care management and coordination

The partnering organizations can achieve much more efficiencies that benefit patients through the approaches indicated in the first two bullets, compared to more limited gains indicated in the last bullet.

Sidebar 1. Organizational Capabilities for the Value-based Business Model

Clinical Integration. Clinical and economic alignment of physicians, nurses and other providers across the care continuum furthers organizational goals around quality improvement, efficiency, and strategic and financial sustainability. Considerations include shared hospital-provider incentives, and relationships between physicians and other care team members.

Quality and Care Management. To continue meeting the increased health and health care needs of patients in their communities, hospitals must achieve high-quality and consistent care outcomes. Considerations include quality and care-management infrastructure and use of team-based and coordinated care delivery models to improve quality metrics, reduce readmission rates and meet other expectations of networks that are forming.

Network. A network that includes hospitals, physicians, post-acute providers and other delivery system partners—enables an organization to provide the full continuum of services in its community or participate as a contracted provider in a network offered by another entity. Issues that require consideration include breadth of specialist and primary care service offerings, relative size of operations, referral sources, service area and overall network accessibility.

Operational Efficiency. Operational efficiency is required for sustainable financial performance in the short and long term. Considerations include operating cost, structural costs, service network and clinical variation.

Clinical and Business Intelligence. Collecting, analyzing and using clinical and business data are critical to setting appropriate goals and intervention targets and to performance management. Considerations include acquisition of clinical and administrative tools, ongoing data collection and management, data analytics and the integration of findings with organizational plans.

Financial Position. A sound financial position enables organizations to make the investments needed to manage population health in their communities.

Customer Engagement. Organizations that can innovate in network development and contracting, attracting employers, payers and consumers, can enhance their essentiality.

Leadership and Governance. Deep bench strength of clinical, administrative and governance leadership drives operational and strategic change. Considerations include current and prospective physician leadership, administration depth and succession, incentive alignment and board health care expertise.

Source: Kaufman, Hall & Associates, LLC

KEY CONSIDERATIONS IN PARTNERING FOR POPULATION HEALTH MANAGEMENT

Participation in managing population health under risk-bearing or value-based arrangements is *the* clinical/business imperative for hospitals and health systems. Organizations that commit early to building the competencies and infrastructure required to advance population health can position or reposition themselves to achieve a sustainable role in their communities.

Depending on the role the hospital or health system expects to play in population health management, critical capabilities include the ability to accept and distribute provider risk and/or health plan risk (see Sidebar 2). Also required are skill sets described earlier, including comprehensive care management, network development and others.

As described earlier, population health management requires partnerships to deliver services across the care continuum at an affordable cost and appropriate quality to the community. Partnerships enable such benefits as: one-stop shopping for health care consumers and other purchasers; a robust delivery network capable of delivering services to a broad population; and infrastructure, innovation and information systems to experiment with and implement best practices and new care delivery models.

Most hospitals and health systems will not have every element of the care continuum illustrated in Figure 1. A limited number of sophisticated organizations will be able to have a health plan, but many organizations will position themselves to deliver services and assume risk under delegated-risk agreements with other organizations.

Expertise and partnerships to create a post-acute offering within the population health management framework will be particularly important given the importance of improving patient care by eliminating unnecessary admissions and readmissions to acute care from post-acute care settings, and the prevalence of arrangements that bundle acute and post-acute care delivery.

Sidebar 2. Types of Risk Assumed by Hospitals and Health Systems

Risk in population health management contracting arrangements for hospitals and health systems falls into two categories:

- *Provider risk* is assumed by the entities delivering health care services, and includes two types:
  - *Clinical or performance risk*, which is the ability to deliver patient care that exceeds the targets for safety, quality, compliance and other measures defined in the risk contract with the payer.
  - *Utilization or financial risk*, which is incurred by a provider organization through acceptance of a fixed payment in exchange for the provision of care anticipated to have an expected level of utilization and cost.
    - Hospital- or insurer-owned plans that are contracting with providers for the providers' provision of care under capitated arrangements are not technically taking on *provider risk* but rather are delegating such risk.
- *Insurance or plan risk* is assumed by hospitals and health systems that have their own insurance plans, with responsibility for attracting and retaining members and the overall costs of plan administration and/or care delivery.

Source: Kaufman, Hall & Associates, LLC

In developing a population health management venture, consideration of seven interrelated issues is important: 1) strategic intent; 2) network development; 3) population health management functions; 4) health plan operations and risk; 5) products; 6) economic integration and provider risk; and 7) asset contribution and exit provisions.

Strategic Intent

Consideration of strategic intent involves asking: What do we want to achieve and how will our success be defined and measured? Typically with population health management arrangements, partnering objectives center on the delivery of coordinated care across the care continuum, as achieved through the physician network and its governance, the delivery of specific services in targeted areas and/or population health management-focused predictive analytics and IT infrastructure.

An example is the partnership of Centura Health, a 15-hospital, 6,000-physician health system in Colorado and western Kansas, with DaVita HealthCare Partners, a leading provider of kidney care and a medical group and network management company.

Through a 50-50 joint venture company branded as FullWell, DaVita HealthCare Partners will extend its operations and services to new areas, gaining the benefits of Centura's in-place clinically integrated network, preferred hospital network, community and post-acute services, and population managed under an accountable care organization (ACO) and the Medicare Shared Savings Program. Centura will gain HealthCare Partners' population health management expertise in delivering IT across all components of care delivery to support early identification of patients at high risk for chronic health conditions and real-time feedback on the efficacy of treatments.[10]

Network Development

Consideration of network development involves answering questions including: What delivery elements will be included within the scope of the partnership? Will each be owned, managed, organized, outsourced or excluded? Who will be responsible for each? Who's responsible for designing and developing the network?

Effective and sustainable population health management entails the design and continuance of a high-performance delivery network that covers the care continuum under an optimized contracting strategy. Although many of the traditional strategic criteria for a viable network still apply (e.g., demand for services, access points and footprint, positioning), additional criteria will be needed for a high-performance network under a population health management construct. Specific criteria include:

- *Network essentiality and population health management care continuum:* To be considered "essential," a network must provide the breadth and depth of care desired by the purchaser (a payer or employer), and be able to handle the projected volume of patients. Network essentiality is usually tied to an organization's primary care practitioner network and/or geographic presence, and measured based on the population that can be attributed to the provider delivery network. The larger the population captured or covered by an organization, the more essential it likely is in the population health management paradigm.
- *Network adequacy:* "Network adequacy" refers to sufficiency of access to in-network primary care and specialty physicians, hospital services and other specified continuum-of-care services in a delineated service area. In many instances, service area and network adequacy standards are driven by national and state laws and regulations, which vary depending on the regulator. Adequacy will depend on the population

served, so health systems will need to be thoughtful about whether they are able to build, contract for and deliver an appropriate network, given each population's variable set of requirements.

- *Service and distribution right-sizing and right-siting:* To succeed under value-based arrangements, many organizations need to systematically reconfigure their networks of facilities and practitioners to be highly efficient, deliver consistent quality across all sites and manage patients in the least-intensive setting possible while still providing the necessary level of care.[11] Unnecessary duplication of services must be eliminated. Proactive providers are working hard to determine the best combination and location of services and programs across inpatient and outpatient sites, and across virtual services, such as telehealth.
- *Network size:* As population health management-based value arrangements reshape utilization, many hospitals and health systems will need larger attributed or accessible managed populations to support organizational infrastructure and associated costs. Growth typically requires expansion through strategic partnerships or affiliations with employers, providers or health plans.

These criteria are not mutually exclusive and each has certain nuances that will be important for hospitals and health systems to understand and evaluate.[12]

As organizations determine the right breadth for their network, trade-offs will be apparent. The broader the network, the harder it typically is to manage consistency of clinical practice throughout the system—especially without vested and aligned partner entities. However, the narrower the network, the more difficult it will be to manage the risk associated with a more limited patient population base.

Population Health Management Functions

Consideration of population health management functions involves answering questions including: Who's responsible for the chief population health management functions, such as population health analytics, care coordination management tools and utilization management? What's the desired relationship with this entity?

The key issue for these functions is the degree to which they are centralized and fully developed in a population health management-purposed entity as opposed to remaining in the providers' or health plans' care management departments. To the degree that the capabilities are centralized within a population health management entity, the entity may justify a care management payment from payers or employers who contract with it for services.

Health Plan Operations and Risk

Consideration of health plan operations and risk involves answering these questions: Who brings to the arrangements the insured member lives and the insurance license? Does the organization need health plan capabilities to achieve its vision? Capabilities include marketing and sales; claims management; network management and operations; product development; actuarial services; business intelligence and customer service. If the answer is "yes," does it need to be full capability or can selected plan capabilities be assumed by another entity? If the answer is "no," what's the desired relationship with the entity that brings the attributed lives to contracting arrangements?

Provider-sponsored health plans are health insurance products or plans that are owned and controlled by one or more hospitals or health systems. The organizations have an insurance license, and they market insurance products directly to consumers. With plans owned by health systems, the systems manage not only the total cost of care but also the full financial risk for insuring the patient. In exchange, they receive and administer the full premium payments.

In certain geographic areas, provider-sponsored plans can be a significant benefit for hospitals and health systems if they have an appropriate number of managed lives and are underwritten, operated and marketed in a manner consistent with the overall strategic plans of the provider sponsor(s). In certain circumstances, there may be an opportunity for providers to either join with existing multiprovider-sponsored plans or merge with another organization's provider-sponsored plan. Such arrangements allow organizations to manage population health without assuming full financial risk for an insurance product, or for sharing ownership of other entities along the care continuum.

Health plans are being acquired or newly developed in various parts of the country. In the Midwest, for example, a subsidiary of Ascension plans to buy a Michigan insurer. The insurer would enable the clinically integrated network owned by Ascension and Trinity Health, named Together Health Network, to participate in Michigan's health insurance exchange.[13]

Unity Health Insurance, an affiliate of University of Wisconsin Health (UW Health), and Gundersen Health Plan, a subsidiary of Gundersen Health System (GHS), signed a letter of intent to explore a partnership, which may include a business combination encompassing nearly 250,000 members. The combination could allow GHS and UW Health to manage the health of larger populations. Together, the organizations offer a wide array of products and services and have insurance licenses in Wisconsin, Iowa and Minnesota.[14]

In North Carolina, Cone Health, a provider network with six affiliated hospitals, received a license to offer health insurance plans, likely to include a Medicare Advantage plan, beginning in 2015. It also initiated a joint venture with a Texas-based independent practice association, which will provide the infrastructure to handle insurance claims and policies.[15]

Risks associated with development of new provider-sponsored plans can be significant for hospitals and health systems. But each opportunity is region-specific and organization-specific, and requires thorough evaluation.

Products

Different types of insurance and health plans offer different types of products. Key partnership questions for hospitals and health systems include:

- Who is responsible for developing the product(s)?
- How is the product going to be priced? Who is responsible for this?
- How is the product going to be branded in the region? Who is responsible for this?

Health systems can take a high-level look at population health management product opportunities by considering evaluation criteria such as enrollment size, growth potential, managed care penetration, revenue (premium) opportunity, profitability, regulatory reform environment and population health risk profile. An organization's ability to produce savings through reduced total medical expense compared to baseline fee-for-service metrics while assuring achievement of quality metrics will be critical to the success of such health plan products.

Products have varying degrees of economic integration and shared risk, so overlap with other areas discussed here is likely.

Economic Integration and Provider Risk

Partnership success typically depends on some level of economic integration or alignment around assuming provider risk. The key questions to answer are: What is the primary means of economic alignment (for example, contract, joint venture arrangement or new-company agreement)? What is our anticipated revenue model? Discussions around the revenue model inform the population health management network and product design.

Hospitals and health systems will need to determine the level of provider risk they wish to assume, ranging from low-risk, pay-for-performance to case rates (episode-of-care or bundled payments), to partial or subcapitated risk, to delegated and shared risk, and up to full global capitation.[16]

Level of exclusivity between the parties is another important issue. Blue Shield of California's ACO arrangements with 31 providers across the state are examples of nonexclusive, contract-based partnerships that align financial incentives and shared governance. Blue Shield sets an annual global budget of total expected spending for the care of an established member population. The budget is developed from data and analysis shared by Blue Shield with the provider groups. The parties agree to share risk for achieving the savings targets. Success requires that the organizations work together to improve care quality while taking cost out of the delivery system.[17]

Asset Contribution and Exit Provisions

As organizations consider the commitment of financial or operational assets to a partnership, the key questions to answer are: What assets are we potentially contributing to, or investing in, for this venture? Often-contributed assets include care management programs, physician practices, facilities and other resources. What assets are we *not* contributing to this vehicle or venture?

Important questions to answer related to exit provisions are: Under what terms could the partnership be terminated and by whom? What recourse exists for each party?

Sidebar 3 is a checklist of recommended considerations for partnerships to manage population health.

Sidebar 3. Checklist of Recommended Considerations for Population Health Management Partnerships

- ❑ Commit early to building the competencies and infrastructure required to advance population health
- ❑ Recognize that owning or operating every element of the care continuum typically will not be feasible; partnerships likely will be needed, particularly with post-acute offerings
- ❑ Know what you want to accomplish with a partnership arrangement, and specifically how success will be defined and measured
- ❑ Define the network delivery elements that will be included within a partnership's scope, and who is responsible for each element
- ❑ Determine where responsibility will lie for functions such as population health analytics and utilization management
- ❑ As appropriate, thoroughly consider arrangements that will allow your organizations to manage population health without assuming full financial risk for an insurance product
- ❑ Evaluate types of products offered through insurance and health plan partnerships
- ❑ Determine the level of provider risk your organization wishes to assume
- ❑ Identify the means of economic integration offered by a partnership, and the expected revenue model
- ❑ Define the assets your organization is potentially contributing to, or investing in, the partnership
- ❑ Determine the terms under which the partnership could be ended

Source: Kaufman, Hall & Associates, LLC

PARTNERSHIPS THAT COULD BE CONSIDERED

Partnerships for population health management will cover a wide range of activities, including: broadening the network coverage within the community, region or state; developing clinical and business intelligence offerings (for example, predictive modeling for population health management); extending care management capabilities (for example, evidence-based protocols); the development of health plans that offer specific products (for example, Medicare Advantage, HMO, ACO); and managed care contracting, among others.

Choosing the most appropriate partnership arrangement depends on the goals and objectives of the partnership, as described later in this guide. Sought-after population health management-related benefits often include enhanced service distribution and physician engagement; value-based contracting; network participation; or participation in ACOs and clinically integrated networks.

A large number of different types of looser collaborative arrangements are emerging as health care evolves to a value-based model. These creative affiliations are seen as a pathway for creating value for communities and realizing some of the benefits of a partnership, without combining governance structures.

Examples of provider and health plan partnerships follow, representing the range of possible options and purposefully including new arrangements, whose track record will be established in coming years.

Please note that many of these examples involve dynamic arrangements, so their description here may not reflect the organization completely accurately at press time. The endnotes indicate the publicly accessible sources used to develop referenced information.

Merger for Population Health Management: AtlantiCare and Geisinger Health System

In October 2015, Atlantic City, N.J.-based AtlantiCare health system officially became a member of Danville, Pa.-based Geisinger Health System, creating the bedrock and accelerant for effective and rapid execution of value-driven, population health-based care delivery in southern New Jersey.

With 600 beds at three locations and more than 700 physicians serving southern New Jersey, AtlantiCare has a strong clinical footprint in its primary service area. It has 65 percent inpatient share, a large network of outpatient sites and was a 2009 Malcolm Baldrige award recipient for performance excellence.

For AtlantiCare, the goal of the partnership is to ensure the future health of the community served in New Jersey through accelerated progress in meeting Triple Aim population health management goals. "Geisinger is well experienced in the technology enhancements and care redesign necessary to successfully achieve the outcomes most meaningful to our patients and communities," notes David P. Tilton, AtlantiCare's president and CEO.[18]

AtlantiCare had been moving to a population health focus before the term *population health* was widely used. With the board's oversight, in the 1980s and 1990s, the leadership team began to develop and execute a plan to change the paradigm of health care from one focused on acute care to one focused on creating health.

Larger covered populations would be needed to ensure the highest-possible quality and to manage the financial risk of doing so. AtlantiCare leadership knew that strategic, clinical and financial resources would be required to obtain and provide population health management-

based services to additional covered lives, and that major decisions related to obtaining such resources would have to be made. The financial situation in greater Atlantic City and emerging success requirements in the early 2010s were beginning to challenge the long-term achievement and sustainability of AtlantiCare's vision and plan on a stand-alone basis.

AtlantiCare embarked on a best-practice strategic options evaluation process, and Geisinger Health System emerged as the best-fit partner opportunity. Geisinger is an integrated services organization that serves more than 3 million residents in 45 Pennsylvania counties. With a reputation for exceptional quality and health delivery innovation, Geisinger owns and operates a health plan with more than 500,000 members, and has affiliations with 3,200 primary care physicians and 23,000 specialists and hospital-based providers.

For Geisinger, the partnership enables growth through scalability of its clinical operations and health plan into a different geography, thereby providing "proof of concept" of its integrated provider-payer health care model. "Our goals are to improve the health status of the community, reduce the total cost of care while improving quality and efficiency, transform care from episodic to value-focused, and provide meaningful coordination across all of health care," said Glenn D. Steele Jr., M.D., Ph.D., Geisinger's recently retired president and CEO.

The initiatives to be pursued by the partners include: implementation of evidence-based medicine programs; enhancing population health management capabilities and clinical services; optimizing the use of the electronic health record and clinical informatics; and successfully using population health- and value-based payment models in New Jersey.

Sidebar 4. Selected Transaction Terms of AtlantiCare-Geisinger Agreement

- Ten-year commitment to AtlantiCare as Geisinger's foundational partner in New Jersey, requiring mutual agreement over any strategic initiatives in southern New Jersey and overall collaboration for the rest of New Jersey and Philadelphia
- Retention of AtlantiCare brand for at least 10 years, with tag line of "affiliate of Geisinger" or similar
- No shutdown or sale of any hospital or major ambulatory campus for 10 years
- AtlantiCare autonomy over annual operating and capital budgets, subject to specified limits, provided specified performance metrics are met
- Three Geisinger voting members added to AtlantiCare System board; one AtlantiCare member on Geisinger System board and one AtlantiCare member on Geisinger insurance board
- Subject to AtlantiCare meeting performance metrics, AtlantiCare retains full authority over personnel decisions and benefit programs
- Geisinger's stronger financial profile provides access to an "AA" credit rating for debt issuance and security for capital and other commitments
- Ability to spend a specified amount of capital over the next five years, provided performance metrics are met; a specified contractual strategic capital commitment, with the first specified amount funded by AtlantiCare, and the next specified capital amount funded equally
- Commitment to jointly developing the regional strategy
- Establishment of an academic training program plan (residency and allied health) to support clinical program growth and physician recruitment

Sources: AtlantiCare and Geisinger Health System. Used with permission.

With an "eye on the greater good of community health," AtlantiCare and Geisinger signed a letter of intent in November 2013 and a definitive agreement in May 2014. Following the regulatory approval phase, the closing occurred in October 2015. Sidebar 4 on page 15 outlines key terms of the agreement.

NewCo Health System: Beaumont Health

Beyond the strategic partnership types already described, also emerging is a new type of partnership that involves the coming together of two entities to create an entirely new company or "NewCo."[19]

Recent examples of these transformational hospital and health system partnerships include RWJ Barnabas Health in New Jersey (Robert Wood Johnson Health System and Barnabas Health) and Northwestern Medicine in Illinois (Northwestern Memorial HealthCare and Cadence Health). Examples also include entities that cross over industry verticals, such as DaVita HealthCare Partners, Inc., which is the combination of dialysis provider DaVita and medical group operator HealthCare Partners.

These transactions typically are characterized by the following:

- Not just a bigger version of one of the former organizations. Rather, the organizations form a new company created by legacy organizations that have set aside their historic interests to do so.
- Common vision and point of view to pursue a much higher level of organizational performance for future success as a model health system centered on community population health.
- Capable of moving at an unprecedented speed of change to reach the transformational goals. *Not* the arrangements taking place one hospital or small health system at a time, occurring slowly during health care's transitional period.
- Partnering arrangement often accomplished through a corporate-style process, which involves a small group of individuals determining many of the details, and announcement near or at the time of a definitive agreement.
- Have overcome extremely challenging hurdles that singly or in combination could derail the partnership process at any point in time.

Some of these partnerships aim to play a major role in organizing care delivery in their service areas. Partnerships may increase scale at such a level that could not otherwise be achieved by one partner through organic growth and/or incremental smaller transactions.

For example, Southfield, Mich.-based eight-hospital Beaumont Health was created through the September 2014 merger of Royal Oak-based Beaumont Health System, Dearborn-based Oakwood Healthcare, and Farmington Hills-based Botsford Hospital.

Beaumont Health is focusing on developing key elements of a value network strategy in the greater Detroit area, including geographic and physical presence; clinical programs and physician alignment; and business infrastructure and partner relationships.

Beaumont Health is governed by a single board and executive leadership structure with representation from the three organizations. A systemwide, physician-led Clinical Leadership Council, including physicians, nurses and other health providers, develops and drives clinical alignment and integration.

Although these NewCo entities are difficult to create, the trend is likely to accelerate and have a significant impact on future health care delivery. Table 1 outlines how these partnerships differ from traditional arrangements.

Table 1. Comparison of Traditional Health Care Partnership Arrangements with Transformative New Entities

	Traditional Arrangements	Transformative New Entities
Impetus	Financial and intellectual capital gap	Common vision for model health system of the future and benefit of scale required to achieve such; thinking the big think
Vision	Survival-driven	Transformation for low-cost, high-quality population health management
Desired speed of change	Driven by current challenges	Driven by desire for rapid repositioning
Time horizon	Meeting challenges of current environment	Meeting the challenges of the future
Nature of arrangement	Buying or selling–adopting the culture and benefits of the acquiring entity	Creating something new and transformative through a much more difficult process of using a data-driven methodology to select best practices
View of who owns	Organization-owned assets	Community assets; no clear buyer or seller
Who leads effort	C-suite-led, board-approved	CEO with core management team and board task force
Process	Typically well-defined by acquirer	Typically undefined, but best-practice oriented
Resulting structure	Acquiring organization	New company
Size of organizations	Large acquires small; or two smalls merge	Organizations of varying sizes come together
Mandatory or voluntary	"Deal" required	Entirely voluntary, but likely required for future success
Development of business case	Disciplined approach sometimes used	Increasing use of disciplined approach, but variation exists; some do, some don't
Expected return on investment	Yes	Yes, synergies identified to help "fund" transformation

Source: Kaufman, Hall & Associates, LLC

Joint Venture Insurance Product: Vivity

A joint venture is any short-term or long-term arrangement between a hospital or other entity and one or more unrelated entities to form and operate a common enterprise that:

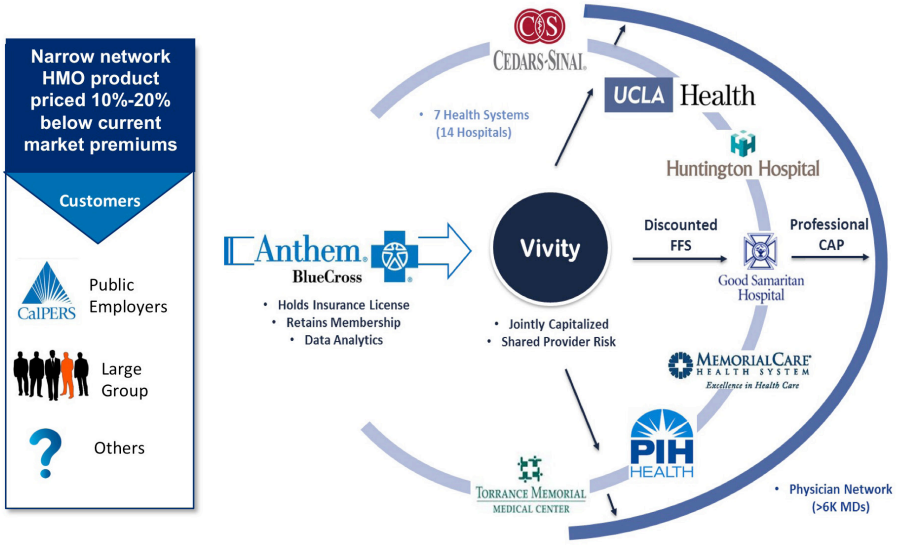
- Pursues a new or existing activity or purpose
- Allows for some level of involvement by the participants in the management, control and/or direction of such activity or purpose
- Provides for the sharing among participants of economic risks and rewards resulting from such activity or purpose

Joint ventures can be structured as any legally recognized form of business organization. In past decades, general categories of joint ventures have included operational or clinical joint ventures, management or leasing joint ventures, and real estate joint ventures. Now, given the emphasis on developing population health competencies, population health management-related joint ventures are emerging quickly in many areas of the United States.

Among the most-watched new arrangements is the Vivity joint venture for a narrow but elite network HMO product. Vivity was launched in September 2014 through a regional joint venture partnership between Anthem Blue Cross and seven hospital systems with strong physician networks in Los Angeles and Orange County in southern California[20] (see Figure 2).

Anthem holds the insurance license, but all parties share risk for new product performance. Vivity was developed specifically (at least initially) for the large-group employer market and is priced competitively with other HMO offerings in the market. Physicians in the hospitals' networks are receiving capitation payments.[21] Savings are expected through elimination of redundant overhead services and lower utilization achieved through highly coordinated and effective care.[22] Although many details are not public, distributions to health system partners are based on quality, performance and equity.

Figure 2. Vivity Joint Venture



Source: Kaufman, Hall & Associates, LLC

The providers are working together to keep costs down, and in the future may use common wellness resources, care management systems and a centralized call center.[23] Reimbursement of the system partners is risk based, and payment requires meeting specific quality targets.[24]

Interoperability of EHR platforms across Vivity is under development. The Vivity partners are balancing business requirements with alignment of provider technology strategies, and have identified an appropriate data integration strategy that also will be leveraged across other Anthem products with the Vivity systems.

Technology-enabled, consumer-friendly offerings to Vivity members are a focus, and include: Live Health Online, a consultative live video chat with a physician; a 24/7 nurse line; after-hours urgent care; and Mobile Health Consumer, an app offering members biometrics, health-risk assessment and information on timely health interventions.

In year one, Vivity met its enrollment targets through contracts with 13 large employers.

Joint Venture Health Insurance Company: Tufts Health Freedom Plan

In April 2015, Granite Health, a partnership of five of New Hampshire's largest health systems, and Tufts Health Plan, one of the leading health insurers in the country with more than 1 million members, announced a joint venture for a new insurance company named Tufts Health Freedom Plan.[25] The goal is to provide residents of New Hampshire with coordinated, high-quality, and cost-effective health care coverage through insurance products and provider networks that focus on population health management. A variety of health plans will be available to employers and their employees. Operations launched in New Hampshire in January 2016.

The five Granite Health systems—Catholic Medical Center, Concord Hospital, LRGHealthcare, Southern New Hampshire Health System, and Wentworth-Douglass Health System—form the core of Tufts Health Freedom Plan's provider network. Network hospitals employ more than 10,000 people, serve more than a third of the state's population, and benefit from shared resources.

For example, a shared data-driven population health management program is producing operational enhancements through sharing of best practices.[26] Initiatives include development of a process that uses centralized and predictive analytics and benchmarking capabilities to inform local adoption of evidence-based standardized care protocols, such as the management and treatment of patients with chronic asthma.[27]

Joint Venture Geographic Network: Together Health Network

In 2014, Ascension Michigan, Trinity Health, and physician partners across Michigan created a physician-led, clinically integrated network of health care providers called Together Health Network. The network includes 25 hospitals, more than 100 ambulatory centers and more than 5,000 physicians. An estimated 75 percent of Michigan residents reside within 20 minutes of a Together Health Network provider.

Together Health Network's objective is to improve both health and care for Michigan residents by facilitating relationships within its network of physician organizations, health systems, insurers, patients, and health providers. At the core of Together Health Network's culture are clinicians connected by a common purpose and meaning; they lead the team-based care approach, which is based on a shared commitment and vision of positive outcomes. The network is designed to position physicians and providers across the state to move into value-based contracts to manage statewide populations of covered lives.

"Both Ascension and Trinity Health have been performing at benchmark levels in terms of quality, while at the same time delivering care at cost levels well below the state average," noted Patricia Maryland, Dr.PH, president of health

care operations and chief operating officer of Ascension. "This collaboration will allow us to combine our outstanding performances in terms of cost and quality into one, statewide product unlike any other."[28] The network will be closely watched nationwide as it moves forward to achieve clinical integration through contracting arrangements.

A clinically integrated network is an organization established to incentivize hospitals and employed and independent physicians to work together to improve outcomes, reduce costs and manage a population's health.[29] Key components of clinical integration include:

1. Collaboration between hospitals and physicians (both independent and hospital-employed)
2. Purposeful agreement to improve quality and efficiency of care, including enhanced patient health status, care outcomes, utilization and other defined factors
3. Use of evidence-based practices and data-driven performance improvement, informed by IT tools to accomplish #2
4. A written arrangement with a payer that aligns financial incentives of the hospital and physicians to accomplish #1 through #3.

Because collaboration and coordination between providers participating in clinical integration initiatives often involve contractual agreements, clinical integration has been subject to definition by the Federal Trade Commission and the U.S. Department of Justice and to their scrutiny related to possible anticompetitive practices under antitrust law.

The legal definition of clinical integration is: "An active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality."[30] This program may include: 1) establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; 2) selectively choosing network physicians who are likely to further these efficiency objectives; and 3) the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.[31]

Management Services Agreement:[32] Novant Health Shared Services

Management services agreements typically involve a contractual arrangement for a larger health care system to provide partial or full management services for a smaller organization. In some cases, organizations enter into service- or expertise-specific agreements, such as for purchasing or clinical best practices that benefit patients in the served communities.

The larger system commonly provides services in exchange for a negotiated fee. For example, the smaller entity may pay management fees equal to a percentage of annual operating revenue, and incentive payments when it meets mutually agreed-upon performance goals.

These agreements typically do not involve a change in ownership or governance and, thus, do not require state or federal regulatory approval. Numerous health systems have used management services agreements to garner some of the advantages of a partnership without having to develop a more integrated arrangement.

For the health system providing management services, such agreements offer a new revenue source and the chance to expand share in an existing area or to establish share in a new area. The economic risk is minimal because the health system does not assume the debt or other liabilities of the managed organization. Typically, the managing entity also does not supply a cash infusion or a commitment to major capital projects.

For strong but smaller managed entities, these agreements may provide the support of a larger, more sophisticated system, while allowing the

managed entity to maintain governance autonomy and independence in providing health care in their communities. Such agreements also may offer an opportunity for financially distressed hospitals to reposition while ensuring the community asset remains under local governance. In either case, the managed entity benefits from access to the larger system's operational and clinical expertise.

Other potential joint benefits include the ability to:

- Share intellectual capital by linking quality programs and best practices
- Achieve back-office and support function synergies
- Integrate IT platforms

Health systems that are looking to expand into neighboring areas may use management services agreements as a growth vehicle through longer-term agreements with multiple smaller providers.

Novant Health, an integrated delivery system headquartered in Charlotte, N.C., developed Novant Health Shared Services to help strengthen health care in local communities and provide an opportunity for growth through partnership arrangements. Novant Health has an extensive network across four states: North Carolina, South Carolina, Virginia and Georgia.

Novant Health Shared Services offers a variety of products including hospital management, supply chain/purchasing, revenue cycle, clinical equipment management, service line management and others (see Figure 3). The key to the shared services model is its flexibility to tailor an arrangement that works for a specific community hospital. The partnering organizations maintain their autonomy and, through access to Novant Health's corporate resources and expertise, achieve improved operational efficiencies and best-practice collaboration across the provider network.[33]

Figure 3: Novant Health Shared Services Offerings

Supply Chain	• Extend group purchasing organization membership • Infrastructure to support advanced sourcing/purchasing, including evaluation of service contract opportunities
Clinical Engineering	• Internal resources available to complete maintenance and repairs of clinical equipment (opportunity to in-source maintenance contract costs) • Single service provider continuity advantage
Quality and Regulatory	• Ability to deploy experienced clinical team for regulatory site visit readiness and preparation • Access to best-in-class quality processes and industry benchmarks
Information Technology	• Capabilities to implement and maintain electronic health records • Additional services include disaster recovery, web hosting and general consulting
Clinical Transformation	• Contemporary health care delivery model implementation • Alignment of shared system clinical guidelines/standards
Other	• Service line development support and analytics • Other areas of expertise include human resources, real estate, construction and development

Source: Kaufman, Hall & Associates, LLC

Brand/Expertise Extension: The Mayo Clinic Care Network

Brand extension involves using a well-known brand name to increase the visibility and use of a new offering. In health care, brand extension offers an affiliation option that is used by well-known organizations that have built strong reputations and name recognition in their regions and/or nationwide or worldwide. The Mayo Clinic is one such organization.

In 2011, Mayo Clinic established the Mayo Clinic Care Network, which extends Mayo Clinic's knowledge and expertise to providers interested in working together to improve the delivery of health care. The network consists of like-minded organizations that share a common commitment to improving the delivery of health care in their communities through high quality, data-driven, evidence-based medical care. Members are invited to join the network following a comprehensive evaluation process that includes a thorough assessment of the organization's governance structure, clinical practice and business practices, as well as its quality, safety and service efforts.

With more than 35 members that comprise over 100 hospitals, the network has members across the country and in Mexico and Singapore (see Figure 4). The network was established to deliver a clinically meaningful relationship that includes access to the latest Mayo Clinic knowledge, helping network members care for their patients while retaining the organization's autonomy.[34] There is no cost to patients when their doctors consult with Mayo physicians about care.[35]

Figure 4. Mayo Clinic Care Network Members

Source: Mayo Clinic Care Network website: www.mayoclinic.org/about-mayo-clinic/care-network/members/map. Used with permission.

Mayo Clinic Care Network membership is managed on a subscription basis. Member organizations contract to pay for the clinically based services they use from Mayo Clinic. There is no additional cost to the patient. These clinically based services include:

- **eConsults.** Providers within the care network can connect electronically with Mayo Clinic specialists and subspecialists to ask questions about a patient's care. The consultation is documented in the patient's medical record. There is no additional cost to the patient.
- **AskMayoExpert.** This point-of-care tool gives providers access to Mayo-vetted information, including disease management protocols, care guidelines, treatment recommendations and reference materials. The information is available on desktop computers or mobile devices 24/7.
- **eTumor Board Conferences.** Members can observe and participate in live, interactive video conferences where Mayo multidisciplinary teams and network members discuss management of current cancer cases.
- **Health Care Consulting.** Network members can consult with Mayo Clinic experts in patient care, human resources, finance, and other administrative and operational areas. Members customize their own consulting plans to support their unique strategic priorities.

Beyond gaining clinical expertise, network members can enhance their own strong brand presence by adding the Mayo Clinic Care Network logo and trademark to their marketing communication as a secondary presence.

PROCESS RECOMMENDED FOR EVALUATING POTENTIAL PARTNERSHIPS

Achieving a best-fit partnership is more critical than ever for hospitals and health systems. The process for achieving such a partnership is based on strategic-financial assessment and planning. The integration of strategic planning and financial planning involves:

- Analyzing the current field and local service area conditions
- Forecasting of changes related to payment arrangements, demographics and many other factors
- Defining the role the organization will play in its community based on these factors

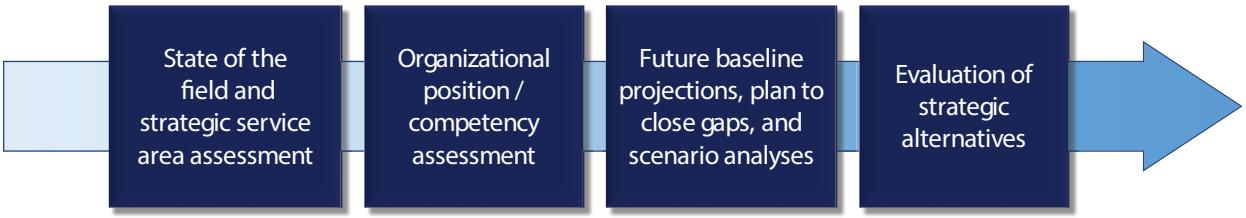
Strategic financial planning that uses solid data and analytics proactively prepares the organization to direct its resources to best-fit partnership options. This approach has two major phases:

- Pre-partnership assessment and planning
- Making and executing the strategic partnering decision

Phase 1: Pre-partnership Assessment and Planning Service Area Assessment

This phase answers questions including: What is the current state and trajectory of the provider field nationally and locally? How well is our organization positioned for the future operating environment? What does our future look like as a stand-alone organization without a partner? What are our big-picture strategic options? Figure 5 shows the four major activities of this first phase.

Figure 5. Pre-partnership Assessment and Planning



Source: Kaufman, Hall & Associates, LLC

Service Area Assessment

As described earlier, the U.S. business model for health care is moving away from a *sick care* model to a value-based system focused on the provision of *health* care in ambulatory and home settings. Service delivery areas are transforming at different speeds. Regions may be at a low or high stage of evolution toward value-based care, but an increasing pace of change is likely and presents significant risk to even the best-prepared organizations.

The organization's current position in its service area can be assessed relative to information on the pace of change in its service area. Pace of change is a function of seven factors: level of organization among hospitals and physicians; employer health care benefits structure; enrollment in public exchanges and level of product and network sophistication; amount of vertical collaboration and new-entrant activity; demand for services; supply of providers; and regulatory environment.

Rapidly moving service areas typically have characteristics, including:

- Large organized groups of physicians and other providers
- Penetration of managed care products and services, including narrow or limited network products
- Relatively high utilization of services and costs of care, on a per-unit and/or total medical expense basis
- Familiarity with capitated payment, including delegated risk models
- Pricing variation across plans and products
- Unused capacity in the service area relative to beds and/or specialists
- New entrants and/or disruptors, including private equity-backed and retail companies
- State legislation encouraging new payment and care delivery models

All of these elements need not be working at the same time to shift a service area rapidly for its providers. In some regions, initiatives by one type of stakeholder may move the needle significantly (for example, a payer which offers a new narrow-network product). In other areas, new entrants accelerate the process. A single decision by a physician group, payer or employer can weaken or completely undercut hospital and health system efforts to gain covered populations through clinical network development, targeted community outreach or other initiatives.

Organizational Position Assessment

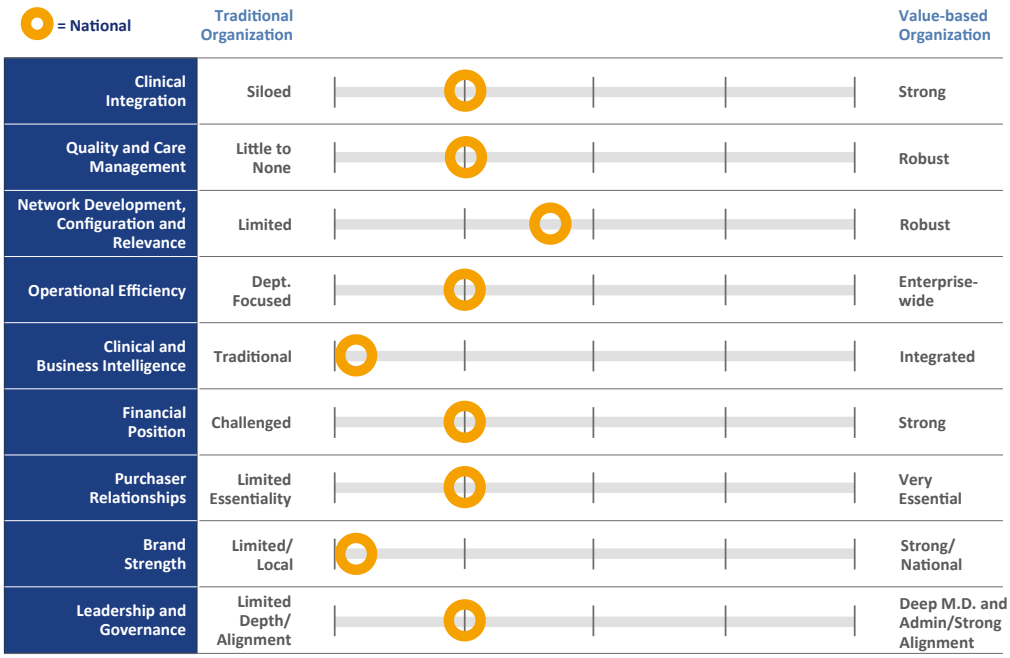
To make the significant changes required for the future, hospitals and health systems need to have as much flexibility as possible. Flexibility will be built through strengthening existing competencies and developing new competencies needed under a value model, as described earlier in Sidebar 1. Each of the eight capabilities is important, but usually a few require significant focus in order to establish the organization's value for payers, employers, consumers and other stakeholders. Key capabilities typically include clinical integration, operational efficiency and quality, and care management infrastructure and protocols.

For the most part, hospitals are aware of the amount of work that needs to be done and

the financial resources required to develop the necessary capabilities. But provider readiness for value-based care varies widely nationwide and leans toward less prepared (see Figure 6). The proportion of health systems that are innovators in linking care quality and outcomes with financial incentives upstream, downstream or across the enterprise will need to increase. Even organizations most frequently cited as examples of the best prepared indicate that they have significant work to do for effective positioning.

Hospital and health system leadership teams should ensure thorough evaluation of the organization's current position relative to the eight critical capabilities, using both qualitative and quantitative data. Each has specific indicators. For example, clinical care management can be assessed based on availability and, importantly, the degree of use of protocols and clinical orders sets for high-cost clinical procedures and high-incidence/high-impact chronic conditions. Financial position can be assessed through profitability, liquidity and leverage ratios, among others. Based on such assessment, the organization's readiness can be compared to providers nationwide and to specific organizations in defined service areas.

Figure 6. Nine Attributes and Estimate of Organizational Readiness on a National Basis



Source: Kaufman, Hall & Associates, LLC

Development and Testing of Baseline Projections

Once competency gaps have been identified, organizations can do the analytic work needed to develop a baseline path to close those gaps. The baseline includes strategic, geographic, clinical, financial and operational considerations. These considerations enable the organization to assess the implications of "staying the course," i.e., remaining independent and without the assistance of a partner.

Because past baselines are no longer appropriate, especially those projections related to future utilization, executives should give careful thought to planning assumptions, including:

- Service area definition: patient origin, demographics and other factors
- Clinical considerations: physician group and staff profiles, programs and service performance, facilities assessment
- Stakeholder environment: payers, hospital providers, ambulatory providers
- Capital considerations: capital/debt capacity, sources and uses of capital, routine capital expenditures, strategic capital requirements
- Utilization: inpatient, outpatient, patient mix, length of stay
- Operating revenue: payment mechanisms (shared risk, bundled, pay-for-performance, capitation, etc.), payment rates (Medicare, Medicaid, commercial, managed care), self-pay net revenue rate, bad debt and charity levels, pricing
- Operating expense inflation: pay increases, medical supplies, interest expense and other expenses

Many hospitals and health systems face significant risk in preparing for performance under a value-based business model. Higher risks typically include volume declines, expense growth, payer rate reductions, and capital expenditures for physician practices and practice losses. It is not unusual for projected baseline financial performance to have a downward trajectory.

The leadership team of one community hospital evaluated such a situation and strategies the organization could use to change the trajectory. The executive team and board were not comfortable with the required magnitude and types of changes, and the associated implementation risks. Leadership wanted to preserve mission-critical services in the community. Sensitivity analyses were performed to indicate potential risks of an improvement plan under different scenarios.[36]

Evaluation of Strategic Options

The hospital's management team and board concluded that achieving the desired performance would be unlikely within the context of regional realities, financial capability and overall desired risk profile if the organization remained independent. Partnership arrangements might help the hospital preserve its mission in the community and position it to play a future role in managing population health.

The independent option becomes the guidepost against which to consider big-picture strategic alternatives. For example, a small independent health system might identify and assess options to:

1. Remain independent and drive aggressively to support its vision, possibly incorporating nontraditional partnership arrangements, such as best-practice or purchasing collaboratives
2. Position itself, either independently or with a for-profit partner, as a regional system that could acquire smaller facilities needing a partner
3. Partner with another health system that shares its vision, creating a new health system
4. Integrate into a much larger health system, perhaps one that is geographically contiguous, or a regional or national system, or a for-profit health system
5. Pursue nontraditional and less integrated partnerships (joint ventures, payer partnerships, etc.)

Having ruled out the financial feasibility of #2, Figure 7 illustrates this organization's high-level analysis of the ability of the other four options to meet strategic priorities. As shown in the right-hand column, option #4—integrating with a larger system—offered the best potential.

Figure 7. Comparison of Four Strategic Alternatives along Eight Priority Dimensions

Priorities	Remain Independent	Pursue Non-Traditional Less Integrated Partnerships	Form New System	Integrate with a Larger System
Alignment of mission and commitment to communities served				
Employees				
Financial sustainability				
Strategic vision				
Dedication to quality improvement				
Medical staff alignment and physician practice management				
Value-based accountable care infrastructure and capabilities				
Governance				

Potential ability to fulfill identified priorities: 

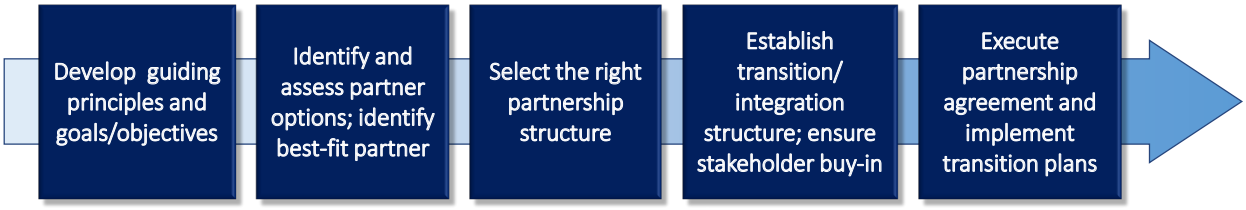
Source: Kaufman, Hall & Associates, LLC

Sidebar 5. Topics for Guiding Principles for Exploring Strategic Partnerships

1. Mission, vision, values and culture: What are the critical elements, and is there alignment between potential partners?
2. Community goals: How will a partnership assure service access and patient satisfaction, handle charity care, as well as promote and deliver health services to meet emerging demographic and service area needs?
3. Strategic plans for value-based care: What are the critical elements, and do the initiatives mesh well together?
4. Clinical programs and services, quality and outcomes, and costs: What are the goals and how will partners collaborate to achieve these? How will a partnership govern the delivery of existing programs and services, develop new services, right-size and right-place major service lines, and increase the quality of care while improving its efficiency?
5. Contracting arrangements, clinical integration, delivery network, IT and other considerations: What contracting arrangements will be sought, and how will the physician and delivery network be shaped to participate in those arrangements? How will IT support the delivery platform? How will a partnership set priorities and timelines for capital initiatives related to managing population health?
6. Physician relationships and commitments: What are the goals and timing expectations related to physician employment, recruitment, contracting and governance?
7. Employees: How will a partnership handle workforce issues, including the retention of executives, managers and employees?
8. Governance considerations: What are the expectations and the desired degree of local-level involvement? How will a partnership involve trustees in setting strategic direction and strategic plans, create operational and capital budgets, and make decisions about the range and scope of health services?
9. Philanthropic and foundation considerations: What are the specific goals? If a new community foundation is to be established, what are the expectations related to its funding?

Source: Kaufman, Hall & Associates, LLC

Figure 8. Making the Strategic Partnering Decision



Source: Kaufman, Hall & Associates, LLC

Phase 2: Making and Executing the Strategic Partnering Decision

Phase 2 has five key activities (see Figure 8) that collectively answer questions including:

- What are the guiding principles and objectives of a partnership?
- What are the partnership options and how do they compare?
- Which organization is likely the best-fit partner?
- What partnership structure would enable both partners to meet their objectives?
- How can an organization help to ensure the timely execution of the partnership agreement and a successful transition post-partnership?

Principles and Goals to Guide Partnership Exploration

The recommended strategic partnering process begins with development by consensus of guiding principles. With oversight and involvement by the board and senior management team, this first step is likely the most important component of this phase. Guiding principles define what the organization wants to achieve through a partnership.

Every organization will arrive at a different set of guiding principles, but current big-picture categories in which health systems develop principles typically include: long-term vision; commitment to partnering organization's community; culture; value-based infrastructure and capabilities; physician engagement; physician practice management; commitment to teaching programs; governance; employees; economies and efficiencies; and financial position. Sidebar 5 outlines nine topic areas for principles that the board and senior management team might consider when initiating the strategic partnership process.

Goals and objectives define the business purposes of the prospective partners. They also provide the framework for all other steps in the partnering process, including the evaluation of potential partners and the selection of the partnership structure. Objectives need to be as specific as possible so that prospective partners can be evaluated on their ability to meet identified needs.

Goals and objectives can be defined at many levels as the partnership exploration process advances, for example:

- The 100,000-foot view might be defined as, "Position the organization to effectively manage population health in specified communities in a value-based care model while maintaining local autonomy for decisions related to health care and medical management." This might be helpful at the stage when an organization is developing guiding principles and overall goals.
- The 10,000-foot view might be defined as, "The partnership will focus on using each other's best practices and infrastructure through the creation of a specific affiliation arrangement." This might be helpful at the stage when the

organization is identifying and assessing best-fit partners.

» The 100-foot view focuses on the business and operational terms of the partnership that will allow the parties to achieve their objectives. It might be defined as, "The combined entity will migrate to one vendor's IT platform within three years." This would be helpful at the stage when the partners are developing a letter of intent, as described later in this guide.

» The ground-floor view defines the specific, enforceable legal terms that will govern the partnership in a manner consistent with the goals and objectives of the parties. This would be helpful during development and negotiation of the definitive agreement.

Realistic objectives increase the likelihood that a partnership will progress smoothly and achieve benefits for both parties. Hospitals and other providers cannot expect to structure an arrangement under which they continue operating exactly as they have in the past. Their boards and executive teams must be willing to be flexible with some aspects of operations, whether it be strategic planning and direction, operating and capital budgets, service continuation and enhancement, or other considerations. Leadership teams should try to put as much on the table as possible and actively manage expectations throughout the partnering process.

At this early stage, the organization typically establishes a structure for exploring a partnership arrangement. A small group or team of key decision makers can speed the exploration and transaction processes and maintain the required confidentiality. The team typically includes:

» Senior management and financial and legal advisers who manage the day-to-day-details

» Small task force of board members, which measures and tracks performance against objectives, provides critical advice on the development of the transaction and reports to the full board at specific stages in the process

Hospitals and health systems should thoughtfully consider the role of the board, management and physician leaders, including both independent and hospital-employed or contracted physicians. Embarking on a thorough leadership and governance redesign process is a major undertaking for internal stakeholders. Advisers may be able to guide leaders through a process that has been successful for organizations in various regions nationwide.

Assessment of Partner Options

In geographies where organizations work closely with each other and know each other well, the choice of a partner may seem clear. Unless the organization plans to undertake an exclusive negotiation process with a single prospective partner, multiple potential partners generally should be identified. These include both obvious candidates in the locale or region and what might be considered "outside-the-box" candidates. Depending upon the partnership goals, potential partners may be in noncontiguous geographies or be a vertical participant, such as a health plan, area employer or retail company. But a realistic rationale for wanting to partner should be apparent for each partner prospect.

Consideration of five or more potential partners as a starting point allows the partner-seeking entity to think broadly. The number of candidates then can be narrowed into a competitive field, as partnership with each candidate is assessed individually and comparatively.

The assessment criteria focus on the organization's ability to meet the agreed-upon partnership goals and objectives. A side-by-side comparison of key elements can facilitate objective review and decision making. The ultimate goal of this stage is to narrow the group of potential partners to entities that have the greatest likelihood of fulfilling the partnership goals and objectives.

Sidebar 6 outlines the formal steps typically taken by the team or task force during this stage. These steps depend upon the level of confidentiality.

In the final analysis, the key elements for assuring good-fit partnerships include:

- Strategic position: The partnership must be able to improve the organization's ability to meet core goals, such as managing population health.
- Operations: The partnering organizations must accurately estimate the investment of time and money required to implement operational change.
- Execution/Implementation: The partnering organizations must make the changes required to achieve the projections used to evaluate the partnership.
- Cultural compatibility: The organizations must assure cultural fit.

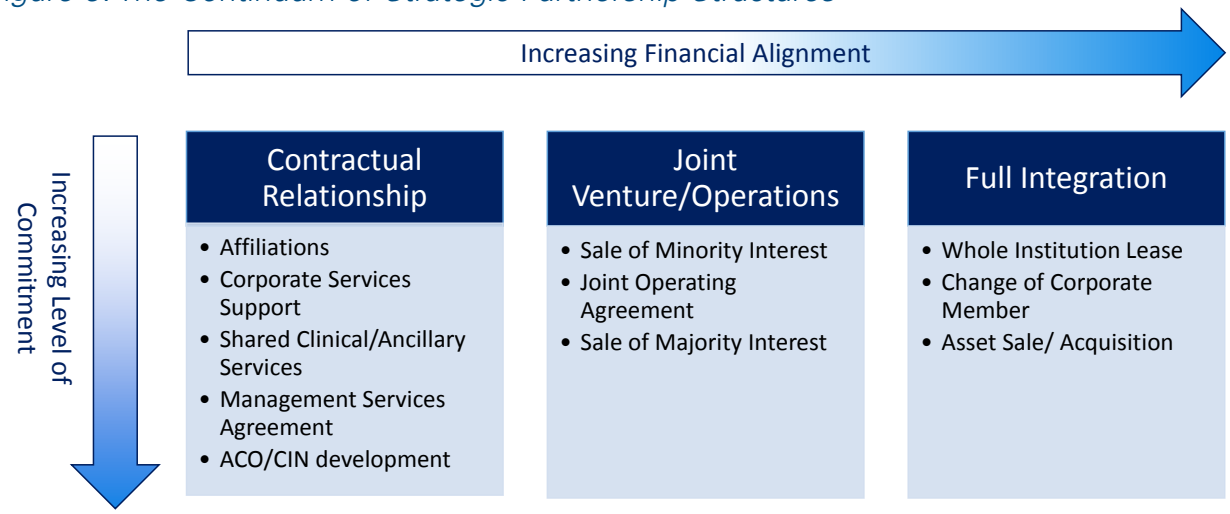
The importance of culture cannot be overemphasized. The top reason cited for nearly half of partnership terminations is lack of cultural compatibility.[37] A well-designed partnership exploration process allows for appropriately timed and confidential interaction between key constituents, including boards, management, physicians and community leaders, in order to gauge cultural fit.

Sidebar 6. Formal Steps in Getting to the Best-fit Partner

- Identify and contact potential partners
- Obtain nondisclosure agreements from each potential partner to assure confidentiality
- Release the confidential descriptive memorandum, which is the primary information disclosure document that formally introduces the partner-seeking organization to potential partners, along with the request for proposal, which requests answers to questions posed by the partner-seeking entity
- Meet with potential partners during site visits, tours and question-and-answer sessions with the management team
- Receive, evaluate and clarify partnership indication-of-interest proposals
- Recommend partner short list or exclusive to board and management task force for go/no-go decision to next phase (partnership agreement negotiation)

Source: Kaufman, Hall & Associates, LLC

Figure 9. The Continuum of Strategic Partnership Structures



Source: Kaufman, Hall & Associates, LLC

Assessment of Partnership Structure

The structure for a strategic partnership is critically important to achieving expected partnership benefits. Structures range from loosely integrated contractual arrangements to fully integrated arrangements, with varying levels of commitment and financial alignment possible in many structures (see Figure 9).[38]

At the most integrated end of the continuum, for example, Baylor Health Care System and Scott & White Healthcare merged, creating a fully integrated health system called Baylor Scott & White Health. Trinity Health and Catholic Health East consolidated as Trinity Health.

Less fully integrated structures include affiliations, purchasing and best-practice collaboratives, clinically integrated network arrangements, management services agreements and others.

For example, the BJC Collaborative is an arrangement that enables multiple health systems to retain their independence, but to partner with BJC and other organizations to increase purchasing efficiencies and share best practices. Carolinas HealthCare System and Cone Health are partnering under a management services agreement. Duke University Health System and LifePoint Health have a joint venture arrangement called Duke LifePoint to build a network of hospitals, physicians and other providers through acquisitions and shared ownership and governance of community hospitals.

An increasing number of hospital arrangements are noncontrol transactions, in which there is no transfer of the majority of a hospital's governance control. Some of the more common noncontrol transactions include:

- Branding arrangements designed to leverage the name, clinical expertise or physician platform of a health system or academic medical center on behalf of an unaffiliated hospital or health system
- Joint ventures targeting a specific service or site
- Management and joint operating arrangements, either for discrete service lines or whole hospitals

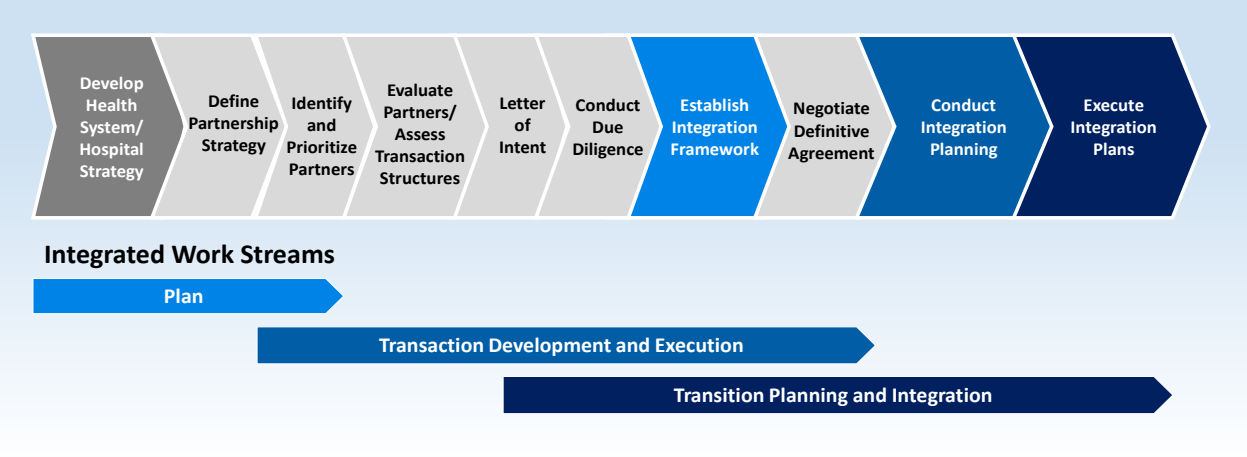
Noncontrol transactions usually involve financial commitments in the form of an investment by one of the organizations in the other, or in a joint venture entity. The nature of the investment can take the form of a loan, a membership interest stake or a contractual right to share in earnings. Many noncontrol transactions also often include specific clinical and programmatic commitments by one or both organizations.

Noncontrol transactions may be attractive to community health systems because they offer an opportunity to partner with a larger organization to help support programmatic needs, while allowing the community health system to maintain more control over its assets and future than under control transactions. In some cases, a noncontrol transaction allows a community health system to get to know a larger partner, recognizing that a more integrated transaction between the parties can occur only after further bridges of trust and collaboration are built between and proven within the organizations.[39]

Choosing the most appropriate partnership structure depends on the objectives of the partnership. If a principal objective of a smaller hospital is to obtain capital support for infrastructure and development, the most likely transaction structure would be a merger with a large organization. If a major objective is to enhance specific service lines or build a clinically integrated network, less highly integrated transaction structures, such as a joint venture or clinical affiliation, may be more appropriate.

Constraints also should be considered. Some structures and agreements have organizational, legal or other operating prohibitions that affect how a partner can participate in this or other arrangements.

Figure 10. Transaction/Transition Planning and Execution



Source: Kaufman, Hall & Associates, LLC

Transition Planning and Integration Structure

Hospital management and governance teams often assume that partnerships occur through sequential steps, the first group of steps consisting of transaction activities (e.g., identifying a partner, conducting due diligence, and developing and executing the agreement), followed by the second group of steps consisting of transition and integration activities (e.g., integration planning and execution).

When this *traditional approach* to partnering and integration processes is applied, it may be driven by the current leadership, and may focus primarily on speed and compliance over organizational buy-in. When this occurs, the partnership objectives are less likely to be achieved during the integration stage and thereafter.

In an effective and sustainable integration process, transaction and transition activities are overlapping, rather than sequential. Figure 10 illustrates the recommended partnership life-cycle, with integration work streams often proceeding simultaneously and involving:

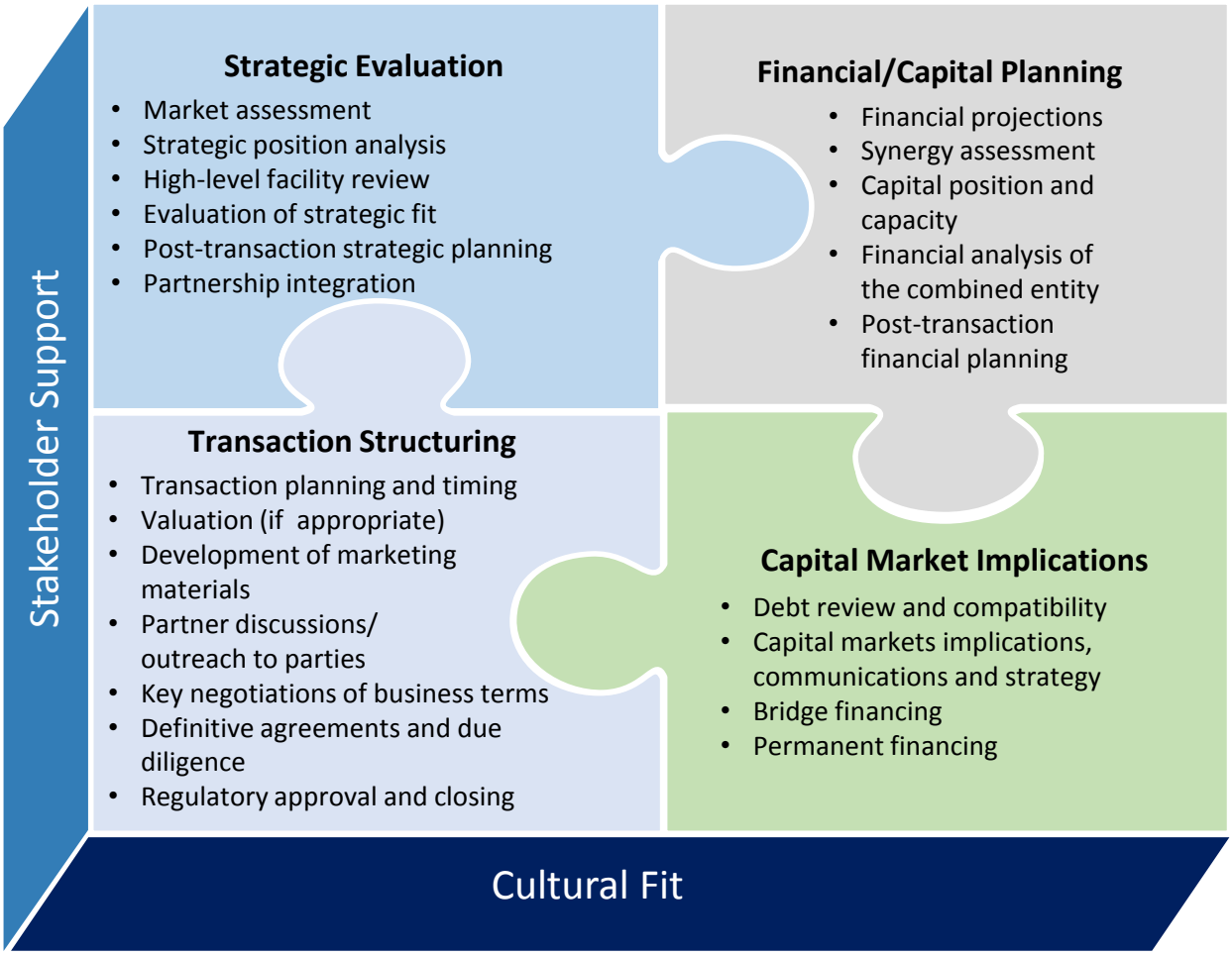
- Strategic planning prior to signing of a letter of intent
- Transaction development and execution through the definitive agreement
- Detailed transition planning and execution, from the letter of intent through complete execution of integration plans

This *integrated approach* is vision-driven and sponsored by leadership, but accomplished collaboratively within and across the organizations.[40] It emphasizes buy-in while attending to compliance, grows new leaders and is sustainable over time, with results that last. Transition planning involves many people, and thus for confidentiality reasons is best started when the partnering organizations are ready to go public with their partnership intent.

Execution of Partnership Agreement and Transition Plans

Before a partnership arrangement is finalized, many successful partnerships have a solid business case or plan that includes financial, operational, strategic and capital rationale, along with qualitative measures of success, including

Figure 11. Elements of a Partnership Business Plan



Source: Kaufman, Hall & Associates, LLC

cultural fit and stakeholder buy-in (see Figure 11). These elements are critical to internal buy-in and support, and important for any regulatory process with significant implications for the ability to meet quality, cost and other objectives across both partnering organizations.

Elements of the transaction-execution process for more integrated arrangements (as shown also in Figure 10), include reviewing and negotiating a letter of intent, conducting due diligence, negotiating and finalizing definitive agreements, meeting preclosing and regulatory review requirements, and closing. Due diligence ensures a more complete understanding of the issues, opportunities and risks associated with the partnership agreement in advance of its execution. Legally binding documents are created to describe the terms of the partnership and the respective rights and obligations of the partnering organizations.

Following execution of the agreement and regulatory approval, the partnership process can go into "full implementation mode" based on the plans developed earlier in transaction and transition planning.

CONCLUDING COMMENTS

Partnerships in health care have accelerated, as participants in the field position themselves for a value-based delivery system. Traditional lines and roles of what were once distinct and separate verticals are now blurring. All types of innovative transactions are occurring.

Providers are showing increased flexibility around partnering arrangements. As larger players combine in unique ways, the pace of change in geographic areas will quicken nationwide. How the business of health care is conducted could be redefined in fundamental and dramatic ways, bringing significant improvements.

What partnerships does your organization need to establish to be an essential provider in your community going forward, navigate the population health management agenda and reposition for a fee-for-value environment? Is your organization moving fast enough now to develop these partnerships?

Partnership discussions are complex and multifaceted, often involving a significant amount of time before coming to fruition through a thoughtful process. As described in this guide, that process includes thorough pre-partnership assessment and planning, in-depth partner assessment and decision making, and development and execution of win-win transaction structuring that meets partners' goals and objectives. Successful partnerships will have in common the elements outlined in Sidebar 7. Forward-thinking health systems are taking a proactive approach to partnership conversations.

Sidebar 7. General Characteristics of Successful Strategic Partnerships

- Common vision on direction and mission of organization and alignment of objectives
- Clear value proposition and compelling strategic, clinical and business plan that can be achieved
- Cultural compatibility, constituency support and implicit trust (boards, management, medical staff)
- Governance, corporate and management structures that support the implementation plan
- Higher degree of "all in" integration
- Strong board and management leadership
- Ability to make difficult decisions upfront
- Organizational champions for key initiatives
- Capability to deliver on commitments related to resources
- Employer and payer support (or, at least, lack of opposition)
- An effective implementation plan that achieves anticipated synergies

Source: Kaufman, Hall & Associates, LLC

ENDNOTES

1. AHA Committee on Research and Committee on Performance Improvement. (2015). Leadership toolkit for redefining the H: Engaging trustees and communities. Accessed at http://www.hpoe.org/resources/hpoehretaha-guides/1787.
2. Health Research & Educational Trust. (2015, August). Approaches to population health in 2015: A national survey of hospitals. Chicago, IL: Health Research & Educational Trust. Accessed at www.hpoe.org/pophealthsurvey.
3. Health Research & Educational Trust. (2014, October). Hospital-based strategies for creating a culture of health. Chicago, IL: Health Research & Educational Trust. Accessed at http://www.hpoe.org/resources/hpoehretaha-guides/1687.
4. For more information on the new model, see Kaufman, K., and Grube, M.E. (2015, Jan. 1). Succeeding in a disruptive healthcare environment. *hfm.*
5. Health Research & Educational Trust. (2015, August).
6. Health Research & Educational Trust. (2014, October).
7. Kaufman, Hall & Associates, LLC, proprietary partnership transaction database.
8. Health Research & Educational Trust. (2014, October).
9. HealthLeaders Intelligence. (2015, Feb.). *The M&A and partnership mega-trend: Deals for growth and survival.* HealthLeaders Media. Accessed at https://store.healthleadersmedia.com/the-ma-and-partnership-mega-trend-buying-power-1
10. DaVita HealthCare Partners. (2015, Jan. 30). Centura Health and DaVita HealthCare Partners introduce FullWell. Press Release. Accessed at http://pressreleases.davitahealthcarepartners.com/2015-01-30-Centura-Health-and-DaVita-HealthCare-Partners-Introduce-FullWell
11. Morrissey, W.W. (2014, Dec.). Reconfiguring your delivery network. *hfm*.
12. For more information, see Grube, M.E., Krishnaswamy, A., Poziemski, J., and York, R.W. (2015, Nov.) Identifying market and network opportunities for population health management. *hfm.*
13. Greene, J. (2015, Feb. 20). Ascension Health subsidiary to buy Michigan health insurer for $50 million. *Crain's Detroit Business.* Accessed at http://www.crainsdetroit.com/article/20150220/NEWS/150229983/ascension-health-subsidiary-to-buy-michigan-health-insurer-for-50m
14. Kaufman Hall. (2015, Jan. 30). Kaufman Hall facilitates Gundersen Health Plan and Unity Health Insurance partnership exploration. Press Release. Accessed at http://www.kaufmanhall.com/about/news/kaufman-hall-facilitates-gundersen-health-plan-and-unity-health-insurance-partnership-exploration
15. Covington, O. (2015, Feb. 4). Cone Health wants to be your insurer. *Triad Business Journal.* Accessed at http://www.bizjournals.com/triad/news/2015/02/04/cone-health-wants-to-be-your-insurer.html
16. For more on this subject, see Pizzo, J.J., Bohorquez, C., et. al. (2013, July). *Value-based contracting.* Health Research & Educational Trust and Kaufman, Hall & Associates, LLC. Accessed at www.hpoe.org/value-contracting

17. Blue Shield of California website: www.blueshieldca.com

18. Kaufman Hall & Associates, LLC, and AtlantiCare. (2016, Jan.). *Partnering for population health: The AtlantiCare/Geisinger story.* Whitepaper. Accessed at www.kaufmanhall.com

19. For more information, see Blake, J.W., and Finnerty, M.J. (2015, Feb.). The new health companies. *Trustee.* Accessed at http://www.trusteemag.com/

20. Ginzenger, B., and Priselac, T.M. (2015, Feb. 11). The Vivity case study: How Anthem converted adversaries into partners. Webinar. Atlantic Information Services.

21. Ginzinger, B., Priselac, T.M. (2015, Feb. 11).

22. Ginzinger, B., Priselac, T.M. (2015, Feb. 11).

23. Vivity website: www.vivityhealth.com

24. Herman, B. (2014, Sept. 17). New Anthem network makes business case for HMO-ACO hybrid. *Modern Healthcare.* Accessed at http://www.modernhealthcare.com/article/20140917/NEWS/309179964

25. Tufts Health Plan. (2015, Mar. 4). Tufts Health Plan and Granite Healthcare Network to launch New Hampshire-based health insurance company, Tufts Health Freedom Plan. Press Release. Accessed at www.tuftshealthplan.com/about-us/in-the-news/2015/tufts-health-plan-and-granite-healthcare

26. Granite Health website: www.granitehealth.org

27. Tufts Health Plan (2015, Mar. 4).

28. Trinity Health. (2014, May 7). Health systems announce launch of physician-led Together Health Network. Press Release. Accessed at www.trinity-health.org/body.cfm?id=196&action=detail&ref=44

29. Adapted from Moody's Investors Service. (2015, Oct. 19). Clinically integrated networks emerging as key to payor negotiations. *Sector in-Depth*, Global Credit Research. Accessed at https://www.moodys.com/research/Moodys-Clinically-integrated-networks-will-play-decisive-role-in-payor--PR_336906?WT.=AM~RmluYW56ZW4ubmV0X1JTQl9SYXRpbmdzX05Id3NfTm9fVHJhbnNsYXRpb25z~20151019_PR_336906

30. U.S. Government Printing Office. (2011, Oct. 28). Statement of antitrust enforcement policy regarding accountable care organizations participating in the Medicare Shared Savings Program. F*ederal Register* (Vol. 76, No. 209). Accessed at https://www.justice.gov/sites/default/files/atr/legacy/2011/10/20/276458.pdf

31. Federal Trade Commission and the U.S. Department of Justice. (1996, August). *Statements of antitrust enforcement policy in health care.* Accessed at https://www.justice.gov/atr/statements-antitrust-enforcement-policy-health-care

32. Gish, R.S., and Cyganowski, D.M. (2015, Aug. 17). Management services agreements offer path to efficiency, growth. CFO Forum. Healthcare Financial Management Association.

33. Novant Health. (2014, July). *Industry Insights.* Accessed at https://www.novanthealth.org/Portals/92/novant_health/documents/about_us/2014-07_Industry-insights.pdf

34. Mayo Clinic Care Network website: www.mayoclinic.org/about-mayo-clinic/care-network/about

35. Mosaic Life Care website. Mayo Clinic Care Network FAQs: www.mymosaiclifecare.org/General/Mayo-Clinic-Care-Network/Mayo-Clinic-Care-Network-FAQs/

36. This topic is covered in depth in Sussman, J., and Kelly, B. (2014, June). *Navigating the gap between volume and value: Assessing the financial impact of proposed health care initiatives and reform-related changes.* Health Research & Educational Trust and Kaufman, Hall & Associates, LLC. Chicago, IL. Accessed at http://www.hpoe.org/Reports-HPOE/KH_NavGap_Guide.pdf

37. Tocknell, M.D. (2012, Jan.). M&A: Hospitals take control. HealthLeaders Intelligence.

38. For another view of the partnership spectrum, see Health Research & Educational Trust. (2015, August), p. 18.

39. For more on this topic, see Callahan, J., Allen, P., and Wu, S. (2014, Feb.). Independent partners. *Trustee.* Accessed at http://info.kaufmanhall.com/Article-IndependentPartnersKHA.html

40. Fitz, T.W., Shoger, T., and Kamholz, K.A. (2016, Jan.). Post-merger integration: The board's role begins before the ink is dry. *Great Boards.* The American Hospital Association. Accessed at http://www.greatboards.org/newsletter/2015/post-merger-integration-winter15.pdf

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