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## combining forces to manage the continuum of care

### AT A GLANCE

Many healthcare organizations are pursuing affiliation strategies to effectively manage population health.

Healthcare organizations should take the following key steps in setting such a strategy:

- > Ensuring the strategy aligns with the organization's mission
- > Identifying potential partners
- > Outlining expectations for the affiliation
- > Assessing affiliation structure options

An affiliation can help a healthcare provider achieve efficiencies needed to deliver value-based care, and many options exist. A critical consideration is alignment with mission.

Competitive advantage derived from managing the continuum of care. Increased scale to achieve efficiencies and market strength. New capabilities to provide innovative solutions. These are considerations that continue to drive affiliations in health care.

Providers are pursuing consolidation and affiliation arrangements to operate more efficiently and decrease their cost structure, with the goals of enhancing their financial positions and improving the value of the care they deliver. For many, the best and possibly the only way to achieve the level of clinical and financial integration required to successfully manage population

health is to band together with other strategic partners. There are a number of important factors to consider.

### Key Steps in Setting Affiliation Strategy

When positioning for the future, organizations should have a well-defined vision for their role in delivering care and the partners they will work with to do so effectively. For many, a desirable goal is to establish a clinically integrated network (CIN) composed of a set of providers that follow common clinical protocols, have aligned measures and incentives based on improved value, and obtain joint-payer contracts. This vision is a major departure from the fragmented healthcare delivery system the industry is shedding. However, deciding what specific arrangement is best for each organization—and designing the road map to get there, whether through consolidation or affiliation—requires thoughtful and thorough examination. The following are the key steps in that process.

**Make sure strategy aligns with mission.** The maxim “form follows function” is applicable when identifying the appropriate structure to achieve financial and/or clinical integration. Before an organization can select the optimal method for achieving integration or even begin to identify

potential strategic partners, it must first define the criteria that are essential for it to fulfill its mission. Examples of key vision- and mission-related criteria that an organization should consider when contemplating an affiliation include the following:

- > Strategic criteria:
  - Consistency with the organization’s mission and values
  - Impact on geographic positioning
  - Enhancement of competitive position
- > Financial criteria:
  - Near- and long-term financial stability
  - Revenue enhancement opportunities
  - Cost-reduction opportunities
- > Operational criteria:
  - Ability to influence and increase quality
  - Ability to enhance care coordination
  - Ability to recruit and retain physicians
- > Political criteria:
  - Community/market perception
  - Physician acceptance
  - Ability to improve/maintain positive perception of the organization’s brand

Ultimately, to be effective and symbiotically beneficial, an affiliation relationship must be guided by a clearly articulated vision shared by the affiliation partners. This vision not only should be born from the mission and vision of each partner to the transaction, but also should be rooted in an objective analysis of market dynamics, stakeholder concerns (internal and external), and potential opportunities for adding value to the participating organizations and communities they serve.

**Identify potential partners.** With a clear understanding of the criteria that will provide the basis for the affiliation strategy, it then becomes possible to identify potential partners. For any organization seeking to build comprehensive delivery networks to manage the continuum of care, experience indicates an important consideration is the additional value that successful affiliations bring to the market by increasing the capabilities of each partner. The organization therefore should consider partners whose strengths counterbalance its weaknesses. The optimal form of integration also will become more apparent as the

**KEY ATTRIBUTES OF COMMON STRUCTURES INVOLVING LIGHT AFFILIATION**

Transaction Structures	Finance	Governance	Operations
Clinical/Shared Services Affiliation	Typically, no direct investment  Services provided at fair market value  IT purchase, implementation, and support  Access to group purchasing	Governance and finances are independent of partner.	Limited business office services (e.g., billing/patient accounting)  Physician coverage arrangements  Access to medical protocols  Branding and marketing support
Management Agreement	Working capital loan provided at fair market value rates  Managed care contracting negotiation support at arm’s length.  Management fee as a percentage of net revenues (typical range of 3 to 6 percent)	Ownership and control of assets are unchanged.  Day-to-day operations of hospital are outsourced to a third party.	Administrative functions (e.g., human resources, corporate compliance and risk management, IT, and patient financial services) may in some instances be outsourced to a partner.

facts and circumstances of the parties involved and their strategic priorities come to light.

**Outline expectations for the affiliation.** Before jumping into which strategies are most appropriate and how they should be structured, institutions should have a clear understanding of the “whys” and “whats” of the undertaking—including why the affiliation is desirable and what specific objectives and initiatives are to be achieved. The organizations should address five key questions in particular, both individually and collectively:

- > What are we seeking from an affiliation?
- > What do we contribute to a potential affiliation?
- > What can the other organization offer us?
- > How can the whole be greater than the sum of its parts in this affiliation?
- > How can we successfully implement our desired strategy?

Once these questions are answered, it is possible to identify the type of affiliation structure that best fits the organizations’ goals and further define expectations.

**Assess affiliation structure options.** Healthcare providers considering a strategic partnership have a range of alignment strategies and structures from which to choose. Light affiliations (e.g., shared services affiliations) require minimal capital commitments but typically result in a lower level of integration. Close affiliations (e.g., acquisitions) require large capital commitments and position the organizations for a high level of integration. Certainly, financial, governance, and operational considerations play a key role in identifying the preferred affiliation structure. The first three exhibits in this article present key attributes of some of the more common affiliation structures at different levels of intensity.

**KEY ATTRIBUTES OF COMMON STRUCTURES INVOLVING MODERATE AFFILIATION**

Transaction Structure	Finance	Governance	Operations
Joint Operating Agreement	<p>Financial resources are coordinated among affiliates, as well as asset transfers and other initiatives.</p> <p>Balance sheets remain independent, though net income is shared per formulas.</p>	<p>A joint operating company is formed to share governance and operational responsibility for the affiliating organizations’ assets.</p> <p>Individual boards retain the power to make day-to-day decisions, develop budgets (within parameters), and monitor quality.</p>	<p>Certain administrative activities are jointly managed to provide efficiencies, including strategic budgeting priorities and managed care arrangements.</p>
Joint Venture (JV)	<p>Typically, the for-profit chain contributes cash (or other assets) to the JV, and the partner-seeking organization contributes hospital assets for ownership interest/cash.</p> <p>Net income is shared according to the agreement and is typically proportional to the contribution.</p>	<p>With not-for-profit JVs, board representation of partner-seeking organizations is typically 50 percent, even with a lower amount in contributed assets.</p> <p>Partner-seeking organizations are often able to negotiate reserve rights over certain decisions (e.g., incurrence of debt, change of control, elimination of services).</p>	<p>The for-profit partner manages the JV, subject to the JV’s board oversight.</p> <p>Typically, the partner’s administrative infrastructure supports the JV’s assets, unless otherwise provided by outsourced third parties.</p>

**Too Early Is Better Than Too Late**

Many organizations struggle with the decision of how long it is possible to remain independent and when it is time to pursue consolidation or an affiliation arrangement. The role of the board and senior leaders is to identify the “red flags” early to improve performance or to position the organization for an affiliation while it still has significant value. Most (but not all) provider partnerships are

born out of mounting operational and financial distresses among the partner-seeking organizations. Frequently, independent hospitals or physician groups choose to remain independent for too long, allowing market and economic forces to erode their organizations’ long-term viability. Although local autonomy is maintained for a longer period under this approach, remaining independent for too long lessens or eliminates

**KEY ATTRIBUTES OF COMMON STRUCTURES INVOLVING CLOSE AFFILIATION**

Transaction Structure	Finance	Governance	Operations
Member Substitution	<p>Cashless transaction structure (although capital may be promised for specific projects).</p> <p>Partner has a long-term interest to fund and support longer-term decisions regarding capital investment.</p>	<p>This is the most common transaction involving not-for-profits. The partner-seeking organization amends the articles of incorporation and bylaws so that the partner becomes the sole corporate member.</p> <p>Typically, there is a loss of fiduciary governance for the partner-seeking organization.</p> <p>Depending on size, the partner-seeking organization may have representation on the partner’s board.</p>	<p>The system parent provides administrative leadership and support, including managed care contracting, human resources, patient financial services, and IT support.</p>
Long-Term Asset Lease	<p>Long-term lease of assets to the partner providing access to and use of partner-seeking assets.</p> <p>Full support and funding for capital commitments is provided by the partner, which is responsible for revenue streams, managed care contracting, and control of costs.</p>	<p>Day-to-day management of the hospital is delegated to the partner.</p> <p>Assets and operational responsibility revert to the partner-seeking organization at the end of the lease term.</p> <p>A separate oversight/steering committee may be established to enable the partner-seeking organization’s board to maintain a role in setting organizational priorities.</p>	<p>All operational support and responsibility are provided by the partner.</p>
Asset Purchase/ Acquisition	<p>Cash payment for assets is used to repay any outstanding liabilities that are not assumed by the partner (e.g., long-term debt, current liabilities).</p> <p>If there are net proceeds remaining after repayment of liabilities, a charitable foundation is established to fund programs for community benefit.</p>	<p>This is a more common structure for not-for-profit organizations selling to for-profits. The partner-seeking organization transfers its assets, operations, and certain liabilities to the partner in return for a cash payment.</p> <p>The partner-seeking organization may be invited to participate in the local community board.</p>	<p>All operational support and responsibility are provided by the partner.</p>

partnership opportunities over time because of the likelihood that “best fit” partners either will have already committed to other providers or will have no interest in a rescue mission.

Independent hospitals and physician groups that consider partnerships before financial and operational challenges arise do so from a position of strength, which broadens their partnership options. Proactively seeking affiliation opportunities from a strong position also can improve negotiating leverage related to clinical programs and services, community goals, capital and facilities, and other key objectives.

Rarely do hospitals and physicians seek affiliations as a result of a single event or their performance against a handful of indicators. More often, a combination of forces and market factors make an affiliation increasingly necessary.

Leaders should proactively monitor performance for early warning signs so they can either take steps to improve performance or position the organization for a partnership while it still has significant value. Myriad indicators exist for tracking hospital operational and financial performance. However, there are several “red flags” that, when triggered, demand additional scrutiny.

Financial red flags, for example, include:

- > Flat or declining net patient revenue

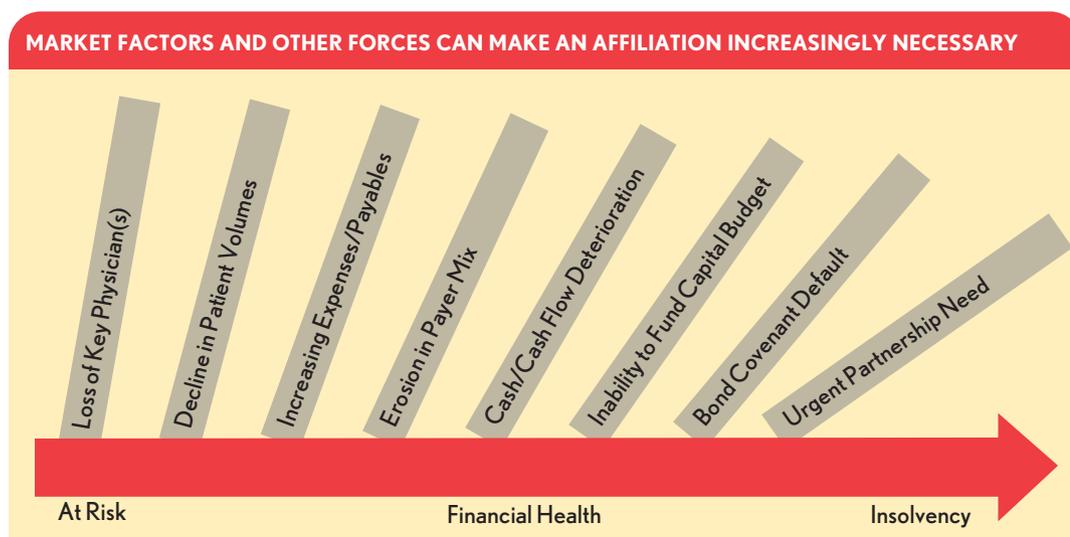
- > Increasing bad-debt expense (an increase from prior period of more than 10 percent)
- > Weak operating cash flow margin (less than 6 percent) and a downward trend
- > Depreciation outpacing capital expenditures (two consecutive years)
- > Low number of days cash on hand (less than 90 days) and a downward trend

Operational red flags include:

- > A year-over-year decline in inpatient/ outpatient volumes
- > A decrease in market share
- > FTEs per adjusted patient day exceeding regional averages
- > Compliance or accreditation problems
- > Loss or realignment of key physicians

**Planning for Integration**

Once organizations perform a rigorous analysis and define the type of arrangement best suited for the benefit of all partners, participants in the arrangement should then plan for integration. True clinical and/or financial integration is not an automatic byproduct of organizational alignment. In fact, leaders often get caught up in the details of a transaction, leaving the matter of integration as an afterthought. The traditional affiliation/merger process involves completing negotiations leading to a nonbinding letter of intent, conducting due diligence, finalizing deal terms, drafting definitive agreements, and then



preparing integration plans. The time between the nonbinding letter of intent and the definitive agreements is typically several months. This is when integration planning should be in full force.

Planning for integration can be structured in a variety of ways depending on the size and perceived complexity of the arrangement. Regardless of the size, however, the project will require a

steering committee, a central project coordinator or project management office (PMO), and teams responsible for completing various tasks (work groups). The exhibit on page 7 presents a sample project structure for the affiliation between a hospital and medical group.

The steering committee should consist of senior executives from all participant organizations,

### Thoughts on the Post-Acute Side of the Continuum

From the hospital or health system perspective, the clear focus of affiliation activities over the past several years has been on acute care services, ranging from alignment and integration of physician group practices to ambulatory care services and complementary acute care inpatient programs. Affiliation and integration with these high-value partners, although complex and often expensive, has been a critical step to achieving the Triple Aim and adapting to reforms under the Affordable Care Act (ACA). Solidifying a provider network has been a priority, particularly in competitive urban environments where providers must be relevant in payer networks to effectively negotiate traditional and innovative contracts. As these acute care affiliations progress, providers should now look to the other end of the spectrum and reevaluate traditional post-acute care relationships.

With the expansion of insurance coverage and the need to deliver lower-cost services, acute care managers should refine operations and throughput to find additional ambulatory care and inpatient efficiencies, particularly in markets where expansion of Medicaid enrollment is most pronounced. Further, incentive payments for quality under Medicare and the “bundling” of acute and post-acute services necessitate stronger coordination and integration with post-acute care partners. Enhanced care management and protocols supported by robust information systems and reporting are providing acute care administrators with the tools to more effectively manage patients throughout this full continuum.

Over the years, acute care providers have opted to include higher-margin services within the portfolio of programs and to close their skilled nursing facilities (SNFs) and home health programs or convert them to acute care services. In most cases, capacity within the market offered by independent SNFs and other long-term care centers provided access for discharge of postsurgical patients and those with other specialized chronic conditions. Generally, these vendor-like

relationships have offered minimal coordination-of-care protocols and few incentives to optimize quality-based payments. This comparative lack of “systemness” is exacerbated by challenges in placing an increasing proportion of patients in specialized, transitional, and long-term care facilities.

Freestanding post-acute operators are similarly interested in deeper affiliations with acute care centers as a means to take advantage of enhanced reimbursement and innovative, accountable payment models. Over the past decade, long-term care facilities have attracted the attention of private equity investors. In general, these investors have seen an opportunity to buy into the provider marketplace at a comparative lower cost, aggregate this fragmented segment of the care delivery system, and begin realizing growth from the elderly cohort of the nation’s population. Now, these operators are gaining the capacity and sophistication to step up and partner in wider affiliation initiatives, bolstered by the reforms of the ACA, which places greater value on lower-cost care delivery, consumers’ demand for quality and patient preferences, and specialized niche providers that can treat chronic conditions more efficiently.

Thoughtful analysis of the financial, operational, strategic, and political implications from deeper integration of post-acute programs is recommended under evolving ACA reforms. Following this exercise, providers can assess whether opportunities to expand the organization’s capacity of a fully integrated network can improve upon status-quo relationships. Acute care administrators are increasingly tasked with creating clinically integrated delivery networks and enhancing population health management competencies. Administrators should take the same approach to evaluating—and potentially investing in—affiliation structures and arrangements with preferred post-acute providers as they are with acute care partners.

their respective legal counsel, and a facilitator. The steering committee’s primary role will be to negotiate the overall transaction structure and discuss and make decisions on the recommendations put forth by the work groups. The steering committee also will provide additional directives relative to the planning process, as needed. These decisions and directives then will be communicated back to the work groups and other interested parties by the PMO through standardized communication and decision-management tools.

The PMO should oversee and manage the planning activities, including all work groups, and should be staffed with personnel who are experienced in healthcare affiliations. The PMO also will serve as a communication conduit between the steering committee and the work groups by interacting routinely with the work group leaders

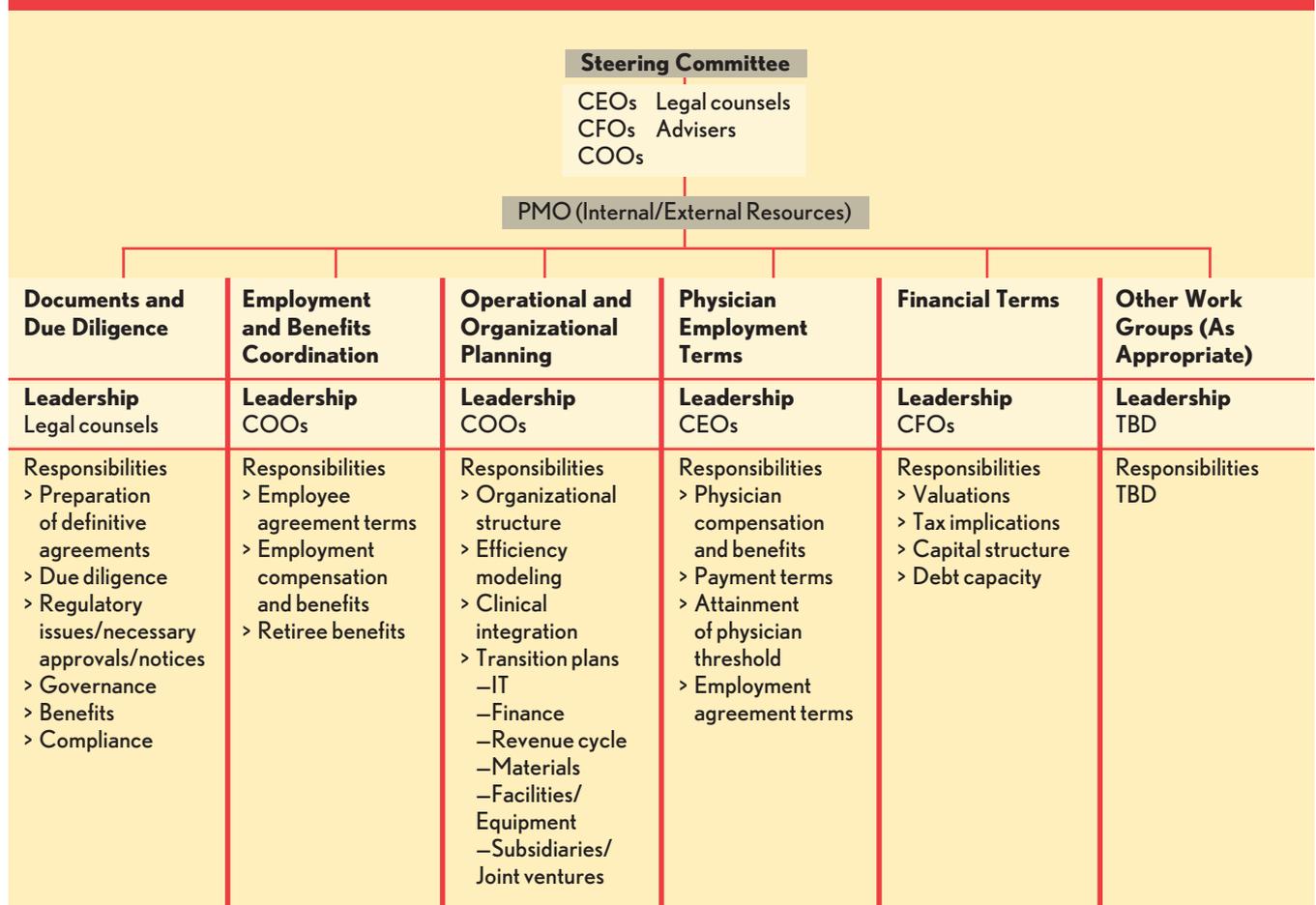
and facilitators. In addition, the PMO will set the steering committee’s agendas, prepare meeting packets, and document key decisions.

Finally, work groups should be identified based on certain functional areas and be responsible for developing recommendations for the steering committee on key decisions pertaining to the definitive agreements and integration plans.

**The Need for a Deliberative—and Unflinching—Approach**

The transition to a CIN will require some form of affiliation for most healthcare providers. Yet the likelihood of success is severely reduced if there are not compelling reasons for an organization to pursue an affiliation. Each organization pursuing affiliation must have the capacity to progress beyond business as usual, both individually and

**SAMPLE PROJECT STRUCTURE FOR AN AFFILIATION INVOLVING A HOSPITAL AND A MEDICAL GROUP**



in collaboration with partner organizations. To be successful, the newly formed relationship should be built upon compatible organizational styles and cultures, as well as mutual trust and respect. Finally, organizations pursuing affiliation should perform their due diligence in creating partnerships or networks that are sustainable and that result in actual integration of the delivery of care and the infrastructure that supports care delivery.

Effective affiliation planning requires a deliberative process that not only encourages innovative, forward thinking but also ensures candid discussion and clear resolution of issues and options. Advancement of the affiliation process is an active exercise. Leaders and facilitators should be willing to engage the most critical and substantive issues by having difficult conversations, challenging organizational biases, and analyzing available

options. Only then can organizations confidently pursue and formalize consolidation or affiliation arrangements that will benefit all participants as well as the health of the population. ●

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