Disruptive Collaboration in Healthcare

March 2018

WRITTEN BY:
ECG MANAGEMENT CONSULTANTS
THOMAS DUTTON, PARTNER, JONES DAY

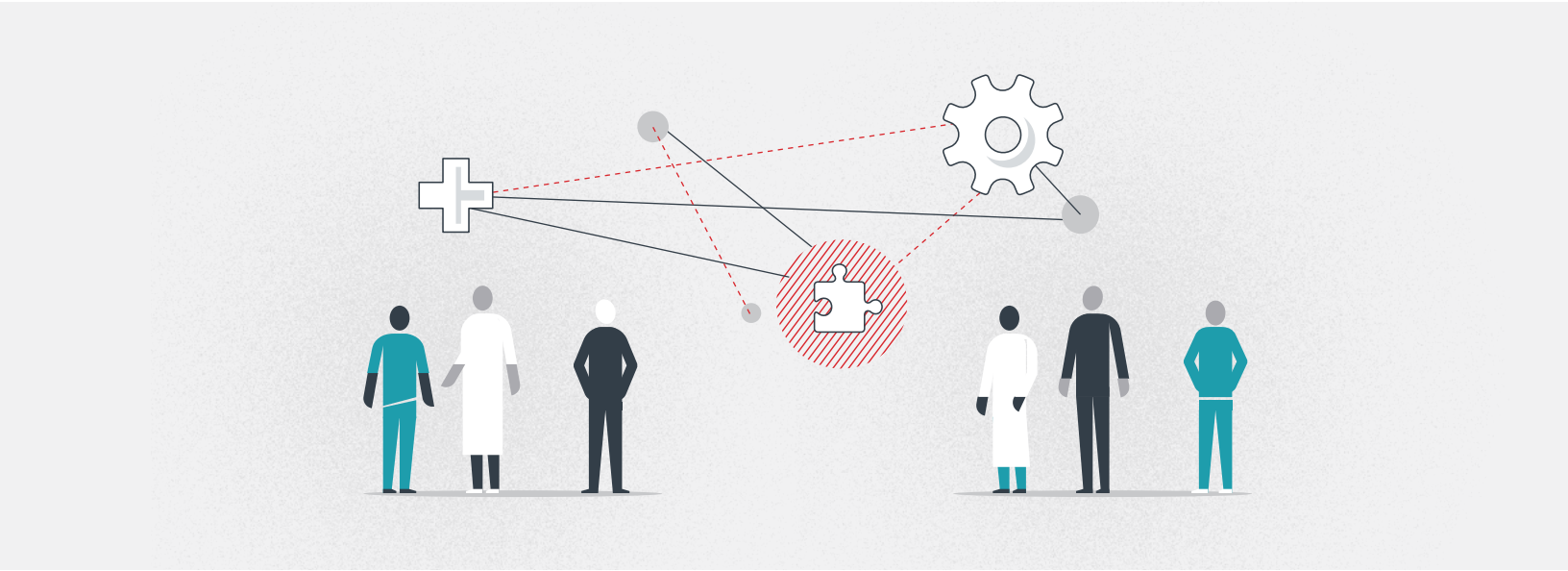
Disruption is evident throughout society these days, and the healthcare industry has not been spared. Look no further than the recent CVS deal to acquire Aetna or UnitedHealth's Optum acquisition of 300 medical clinics from DaVita. The CVS acquisition concentrates market power across different spectrums of healthcare, and Optum's deal makes it look more Kaiser Permanente–like every day—but without the drag of hospital assets. Add to this the recent headline "Amazon, Berkshire Hathaway and JPMorgan Team Up to Try to Disrupt Health Care,"[1] and it becomes clear that disruption is part of the transformation agenda for the future. These transactions support the argument that disruption is just beginning in healthcare. As Christiansen has outlined,[2] disruptive innovation tends to come from outside a given industry. None of the three new entrants to healthcare has a real track record in this field. Their motivation in attempting to reduce costs is largely based on the huge expense that healthcare represents to them and their employees.

ECG MANAGEMENT CONSULTANTS

[1] Nick Wingfield, Katie Thomas, and Reed Abelson (*New York Times*, January 30, 2018).

[2] Clayton Christiansen, *Disruptive Innovation*.

But disruption is not only coming from outside the industry; conventional healthcare organizations are also attempting more disruptive strategies. Historically, initiatives such as the use of hospitalists, ambulatory surgery, and telehealth can be considered part of this category. Less clear, perhaps, are these new forms of disruption through collaboration that are radical in some cases. Slimmer margins and utility-like regulation of healthcare are creating a mandate for scale through the idea of disruptive collaboration.



REMAINING INDEPENDENT?

It is becoming increasingly difficult for hospitals to remain independent. At a time when hospital use rates are declining and major shifts continue toward ambulatory offerings, there is uncertainty regarding government payments. Dramatic regulatory changes are also being experienced, at both federal and state levels. While one in five hospitals may be independent at this time, that statistic is deceiving in that many of them—over 1,500—are smaller *critical access hospitals* that are often quite isolated. As part of their strategic due diligence, many of the remaining independent hospitals are considering how long they can sustain that status.

In a recent issue of *Health Affairs*, a new analysis of 346 metropolitan areas showed mergers increased dramatically between 2010 and 2016.[3] It notes that 90% of hospital markets, 65% of physician specialist markets, and 57% of insurance markets are considered highly concentrated. This level of concentration has been referenced in a number of high-visibility merger discussions in the past few years that have been either successfully challenged by the FTC or DOJ on an antitrust basis or under threat of such challenges.[4] Despite these challenges, there has been a continued

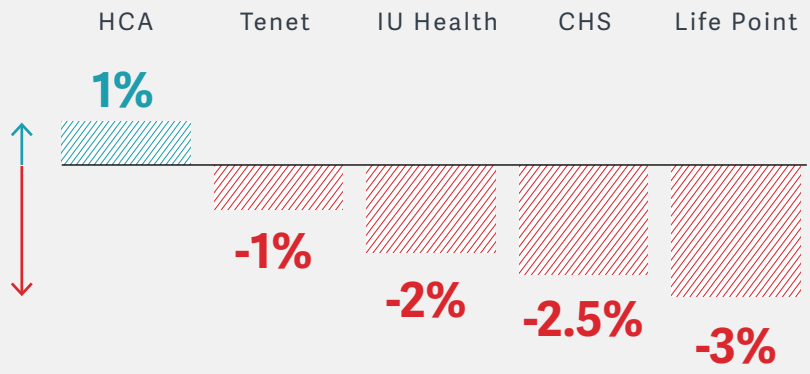
[3] Brent Fulton, "Health Care Market Concentration Trends in the United States: Evidence and Policy Responses" (Health Affairs, September 2017).

[4] Among the examples are the proposed Advocate Health Care–NorthShore University HealthSystem merger and the Partners HealthCare–South Shore Hospital talks. It is noted that Advocate solved this issue by going out of market and adding a proximate market served by merging with Aurora—a merger that recently received both federal and state regulatory approval.

trend toward hospital mergers and acquisitions (M&A), but with several twists. One of these is the increase in for-profit companies working with nonprofit partners. It can be argued that the formation of the equity-based hospital companies—starting with HCA back in 1968 and including Tenet Health, CHS, and others—was a significant disruption to hospital ownership at the time. Previously, equity-based healthcare companies had all seen continued growth. But this changed in 2016 and 2017, as shown in recent slumping admissions (illustrated in **figure 1**) and more care shifting to the ambulatory arena.

Some experts tie these declines to the failures of the Affordable Care Act (ACA) to achieve threshold enrollment and curtail premium increases, and there is some truth to this. But it seems to us the situation is more complicated. Highly leveraged CHS has struggled to find the bottom of its stock value during a period of great turmoil, as it was trying to implement a new regional cluster strategy and needed to spin off its smaller, more isolated hospitals that demanded a different strategy. Mind you, many of these equity firms embraced the ACA during the political turmoil of 2010, believing that it would boost their performance. Part of this optimism by such firms was likely grounded in the belief that most community hospitals would be challenged by ACA and seek partners as a result. Access to capital seems likely to be a constant driver for more hospitals as their footprints shrink and they determine that a capital partner is required to keep their mission alive in their communities. This has translated into transactions where hospitals have converted to for-profit status, indicative of the growth of equity-based hospital companies in the past few years.

Figure 1—*Modern Healthcare* Assessment of Hospital System Admissions



Source: Complied by Modern Healthcare from Q2 financial fillings

There has also been some disruption to traditional models of hospital acquisitions by for-profit firms of nonprofit hospitals (conversions). A key example is where governance has been equal between the buyer and the seller, even where 80% of the hospital was sold to the for-profit partner under a joint venture (JV) approach (i.e., 20% remains owned by the tax-exempt parent corporation of the hospital). This has allowed some transactions to occur with a for-profit partner where nonprofit hospital boards might have previously restricted partnering to other nonprofit organizations. Joint operating agreements (JOAs) and other variations have developed over time where equity capital comes into play with a tax-exempt hospital. But this is only one area where collaborative innovation has taken on new forms.

COLLABORATION BECOMING MORE DISRUPTIVE

Antitrust enforcement, or the threat of it, is one thing that has stymied many potential collaborative discussions among potential healthcare partners. Another inhibitor has been that many hospital boards and executives view full-asset mergers as a last resort or defensive strategy, which has been something to generally avoid. Some organizations have gone so far as to place "independent" in their mission statement, with the implication being that if they can't remain independent, they should not otherwise exist. Yet, counter to this, as Toby Cosgrove, MD, of the Cleveland Clinic warns, "if we do not see consolidation and increase efficiency, we are going to see hospital closures across the country."[5] How do we reconcile these two different points of view? Enter disruptive collaboration. Full-asset mergers are not the only way to approach affiliation. A critical disruption in the collaborative continuum is the emergence of new creative forms that allow the participants to retain a higher degree of independence—what might be termed "partial mergers."

Two recent overarching developments have helped to define new opportunities for disruptive collaboration. The first involves new approaches to shared services and clinical service lines through joint ownership and, in some cases, cobranding and shared risks/revenues. The second involves creative new forms of regional alliances. **Table 1** shows examples of each of these different arrangements arranged by scope, which ranges from rather narrow to quite broad.

Full-asset mergers are not the only way to approach affiliation. A critical disruption in the collaborative continuum is the emergence of new creative forms that allow the participants to retain a higher degree of independence—what might be termed "partial mergers."

[5] T Rosin, "Cleveland Clinic CEO Dr. Toby Cosgrove's Warning to All US Hospitals" (*Becker's Hospital Review*, November 22, 2016).

Table 1 — Examples of Recent Collaborative Arrangements

Case Study	Scope	Description	Implications
Trivergent Health Alliance Management Services Organization Maryland	Shared Services	Formed among three health systems to consolidate staff and oversee six key service lines at three hospitals and provide related management services: HR, IT, Supply Chain, Lab, Pharmacy, Revenue Cycle	Derive operational efficiencies, reduce costs and enhance quality of care.
DukeHealth WakeMed *JOAs for Cardiac and Cancer Services* North Carolina	Service Lines (partial mergers)	AMC and regional health system agreed to jointly operate and share the results of operations of their inpatient and outpatient cardiovascular and cancer services in Wake County (Raleigh).	An effective means to enhance the scope and value of heart and cancer services closer to the patients' homes, sharing financial risk in a manner that makes each party agnostic as to the location of service delivery.
AllSpire Health Partners Maryland New Jersey New York Pennsylvania	Multiregional Alliances	This multistate network was formed to jointly invest in technology and other potential services that represent efficiencies and value-based initiatives.	Significant savings via GPO function and also focused on an innovation center.
Midwest Health Collaborative Ohio		Six otherwise unaligned health systems that are significant players in their local markets join to offer payors statewide coverage.	Creation of multimarket network with shared/ centralized data analytics and care transformation.
MPactHealth Missouri Kansas Arkansas Oklahoma	Multi-State Clinically Integrated Network (CIN)	Comprised of over 3,000 physicians and 50 hospitals, this physician-led and professional managed CIN has successfully used a chapter model to drive value-based care.	Driven by one of the founding system's direct-to-employer contracts with large companies, such as Wal Mart and Bass Pro Shops.

What do all these recent collaborative models have in common? For one, they create greater value than a single hospital or health system can reasonably achieve, through more extensive reach. A key to their success involves the ability to achieve critical mass. In the past, this concept has usually referred to size (e.g., assets, revenues, beds). More recently, it is starting to take on population health nomenclature such as covered lives, new patients, and "share of care." There are numerous variations to what form of critical mass is important in a given market, and each offers some unique advantages and challenges. We've identified three innovative models further discussion: shared services organizations, joint clinical service lines, and multiregional alliances. These are explained in more detail below.

Shared Services Organizations

These organizations are nothing new to healthcare. But the big GPOs of the past are being disrupted by some smaller regional entities, recognizing that critical mass can still be achieved through a more customized approach to supplies expense. In some cases, this may be meant to simply supplant membership in the very large national GPOs. In other cases, like Trivergent, it may be more of a runway to higher levels of collaboration. Tangible benefits are initially focused on scale economies, but the intent is to expand from there toward value-based services. Larger GPOs may experience some difficulty retaining some of their membership under this model, as a scaled-down, locally controlled regional version may be perceived as more responsive to local conditions and thus better able to respond to changing environmental considerations while achieving similar economies of scale.

Legally, such a model can be represented using the traditional alliance/cooperative structure shown in **figure 2**. This involves shared governance and ownership by several organizations that may span multiple markets. Subgroups may form to focus on different components (more on this later).

Figure 2—Alliance/Cooperative Organization Model[6]

[6] Based on a model created by Jones Day.

Joint Clinical Service Lines.

Similar to other forms of integration, clinical service lines have been fostered to create a more seamless experience for patients seeking specific clinical services. These niche service lines have tended to focus on large cohorts of patients, often involving significant chronic disease. There can be little doubt that the aging population has been a key driver of the search for a better experience by a more demanding customer. Heart services, cancer care, women's health, and musculoskeletal services are sometimes viewed as "the big four." But others have commanded significant attention, notably children's services.[7]

Clinical service lines have undergone a number of refinements over the years as they attempted to better coordinate services across the continuum from the hospital into the ambulatory space and become refocused in a value-based world. Performance dashboards are becoming a mandatory requirement for such programs, and the results are often being compared through transparent reporting of key outcomes. While clinical service lines have been around since the 1990s, the disruption comes with new partnerships and more aggressive forms of collaboration.

Some national brands have begun to extend their service lines to regions far-flung from their origins (e.g., Cleveland Clinic, Mayo Clinic, MD Anderson Cancer Center), while others are attempting to become the outsource alternative for specialized services (children's services, dialysis, etc.). And this has not gone unnoticed by Wall Street. Countless firms have been started over the past decade or so focused on various niche services (e.g., wound care) that are being sold into hospital settings. Retail chains have also gotten into the act through convenient care centers (e.g., MinuteClinic) and by offering dispensing pharmacies in some of the larger, full-service ambulatory centers that have been developed by a variety of players.

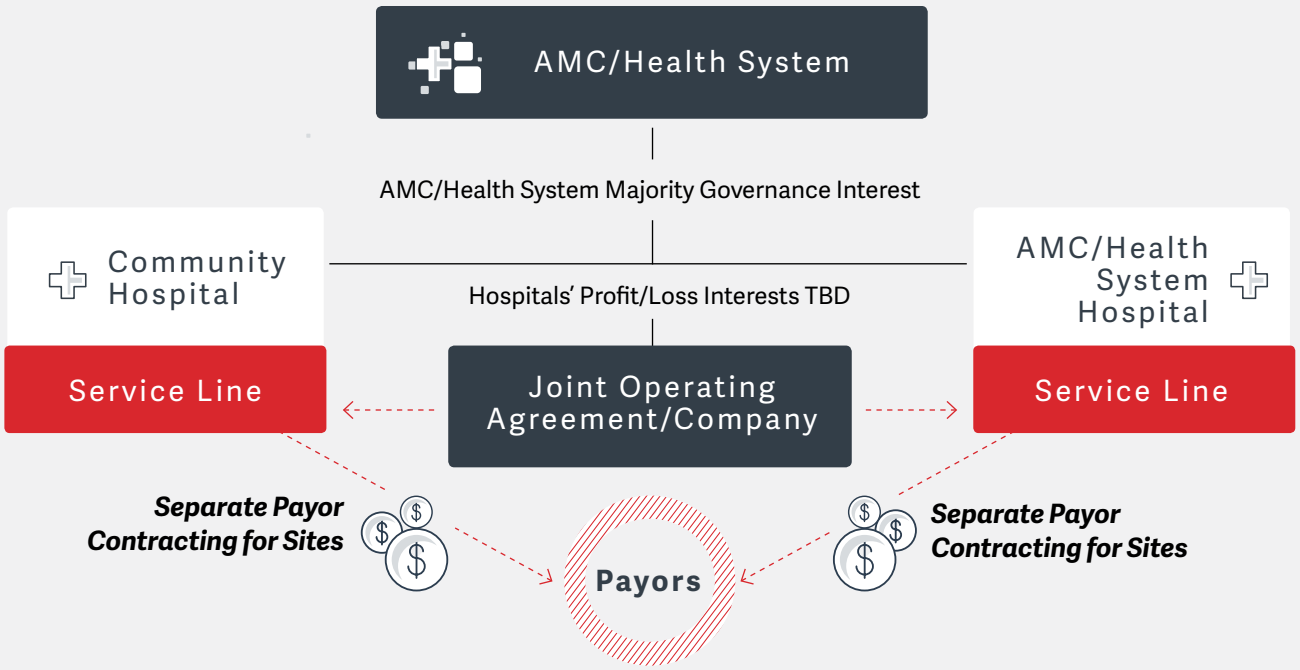
These new arrangements are a departure from the "brand-sharing" approach that seemed to dominate service lines in the past. Under such arrangements, community hospitals would attempt to tether their program to a recognized brand. Unfortunately, these affiliations often involved little more that invoking the recognized name; clinical programs did not change, there were no assets exchanged other than "renting" the brand, and the product remained otherwise the same. After a number of trials and errors, brands such as MD Anderson and Cleveland Clinic pulled out of some of these early ventures. New collaborations are far more sophisticated and feature a number of innovations, including what could be characterized as "partial mergers." These involve:

- ***Shared expenses and a shared bottom line.*** This may include all direct revenues and expenses or just the marginal amounts above a baseline (i.e., growth).
- ***Cobranding.*** Conceivably one or more of the parties will gain recognition through another party's brand being tied to the program.
- ***Shared risk at all levels.*** The participants are individually and mutually at risk. In fact, each party may maintain their own payor contracts but roll up the results into a joint arrangement.
- ***A site-neutral approach/vision.*** The intent is to jointly market the services of the various organizations without regard to where the patient actually receives the care. For example, when a community hospital links with a children's specialty facility, services can be critical in creating an environment that favors treating the patient in the lower-cost setting except when high-intensity care is required.

[7] Note the use of consumer-friendly terminology. While not all providers have adopted this, doing so recognizes the growing influence of the consumer (and their family) in the provider selection process.

This type of arrangement can take on a variety of legal forms. One of the more intriguing models, illustrated in **figure 3**, has been used by Jones Day and other firms to integrate community hospital service lines with academic medical centers.

Figure 3—Service Line Revenue Merger



Services must be located on main campus of hospital *to be provider-based for Medicare purposes; off-campus locations are still provider-based for commercial insurers.*

In a multisite service line revenue merger, the community hospital and the AMC/health system enter into a JOA to create a joint operating company (JOC) to operate (and share the results of operations of) the subject inpatient and outpatient services. The AMC/health system usually has a majority governance interest in the JOC, which manages the subject services. The parties' relative profits/losses, as well as governance and management interests, are set forth in the JOA. The JOC governing board is given governance authority over the subject service line (development of operating and capital budgets, strategic planning, services, locations, physician manpower, etc.). The contribution margin (income/loss) above an agreed-upon baseline from each party's service line will be combined and reallocated based on the parties' respective profit/loss interests. Importantly, each hospital continues to include the subject services under its own payor contracts.

Multiregional Alliances

Considerable variation characterizes the third collaborative model, which has been labeled multiregional alliances or strategic regional health organizations (SRHOs). Unlike some of the national health systems that operate in multiple regions, these new alliances operate in contiguous regions where product can be offered jointly, including both clinical programs and insurance products, even where they straddle multiple states. Rather than a single control vehicle of several national systems, these regional systems remain independent but join to pursue certain initiatives on a joint basis. One variation on this approach is a simple investment in new technologies. The intent is to focus on investment in predictive analytics and care models that have the potential to better control the cost of care. These groups are essentially interested in sharing services where additional savings can be derived and in functioning as innovation incubators. One such alliance was initially formed among seven "mature" health systems from two contiguous states through an initial investment by each participating system. Achievements were hard to come by in the early years, when part-time leadership rotated from one member organization to another. A few of the members have been consolidated or left the alliance, but they have derived considerable additional savings through the use of a single GPO for all their major purchases, and more initiatives are actively in the works.

Many of these multiregional alliances seem to be composed of large members that have effectively saturated their local regions. Their ability to grow any further through mergers or acquisitions in their existing markets may be severely limited, as discussed earlier. Believing that greater efficiencies are still possible through collaboration, including growth across a larger geography (e.g., statewide), mature regional systems are coming together to pursue this common agenda. Cleveland Clinic can't add any more hospitals in Cleveland, but it has become part of both a national employer alliance and a multiregional alliance (Midwest Health Alliance) to effectively cover the full state of Ohio. Recently, 14 of these multiregional alliances (Strategic Regional Health Organizations [SRHOs])[8] joined together their own national association. While the forms of these alliances vary somewhat, as do their visions, they all share a recognition that payments are shifting toward value and that this will require more sophisticated data gathering and manipulation in order to truly manage care and control costs.

Despite the different scopes and forms of these alliances, the ultimate goal is to offer care through a CIN that extends the combined market beyond the existing reach of any individual member. Single-signature contracting is not yet evident within these SRHOs but incorporating it with the ability to manage care under risk-sharing arrangements could become a game changer, especially if it is integrated with transformations to care delivery. Clearly, synthesizing the finance and delivery of care is being pursued in many forms, as noted by a recent estimate that provider-sponsored health plans have expanded to the point where they now represent as much as 52% of all insurance products available.[9] Again, these are not just joint contracting vehicles to secure statewide or national contracts. Securing a risk contract is one thing; managing care successfully under such a contract is something different. These new arrangements are very focused on developing the analytics and the ability to manipulate claims-based data and medical records in ways that will improve care delivery, especially to the higher-risk patient cohorts that are consuming the majority of healthcare resources.

Legally, these multiregional systems tend to apply the alliance/cooperative structure noted earlier. It is under these arrangements that subgroups often form to pursue a variety of innovative initiatives. Some form of population health management and managed care contracting tend to be present, giving rise to a particularly interesting dimension to these SRHOs. By inverting the traditional holding company model to a joint ownership arrangement, the participants can jointly own risk and dramatically reduce their antitrust exposure. An issue to be confronted by all such organizations is the extent to which the members use an opt-in or an opt-out investment approach to their strategic initiatives.

[8] This is the term used by SRHO, the National Association, which had its inaugural meeting in 2016. For additional information contact Darin Libby, who is the ECG lead providing advice to the association, or go to the website at http://www.srho.org.

[9] According to Atlantic Information Services as reported in *Becker's Hospital Review*, 2017.

CONCLUSIONS

Many hospitals and health systems are already involved in or actively exploring new models of collaboration. This article has tried to capture some of the nuances of these new arrangements and document just how disruptive they are. With so many new forms, it is clear that collaboration is no longer a "one size fits all" strategy. Time will tell if these arrangements will create new value and/or provide relief from onerous regulations. The early returns seem promising, especially with merged service lines, examples of which seem to be expanding. It may ultimately be that the ability of these disruptive arrangements to flourish will hinge on the willingness of boards and CEOs to cede some control to a jointly owned entity. The traditional need of healthcare CEOs to own and control may make this bridge too far for some. But disruptive affiliations do offer a departure from the all-or-nothing merger approaches of the past. These new forms make it possible for leaders to get comfortable with collaboration, as they still allow for a high level of autonomy. It seems likely that more robust collaboration will become a core strategy pursued by many healthcare organizations in the future. Disruptive collaboration is bolstering the ability of regional health systems, in their various forms, to position themselves favorably in the value-based future for which healthcare appears to be destined.

For more insights from ECG, visit www.ecgmc.com/thought-leadership.

the Authors

ECG Management Consultants

Jones Day:

THOMAS E. DUTTON, ESQ.
Partner
Jones Day
(614) 281-3897
tedutton@jonesday.com

ECG MANAGEMENT CONSULTANTS


ECG
MANAGEMENT
CONSULTANTS