Modernizing Mission Support

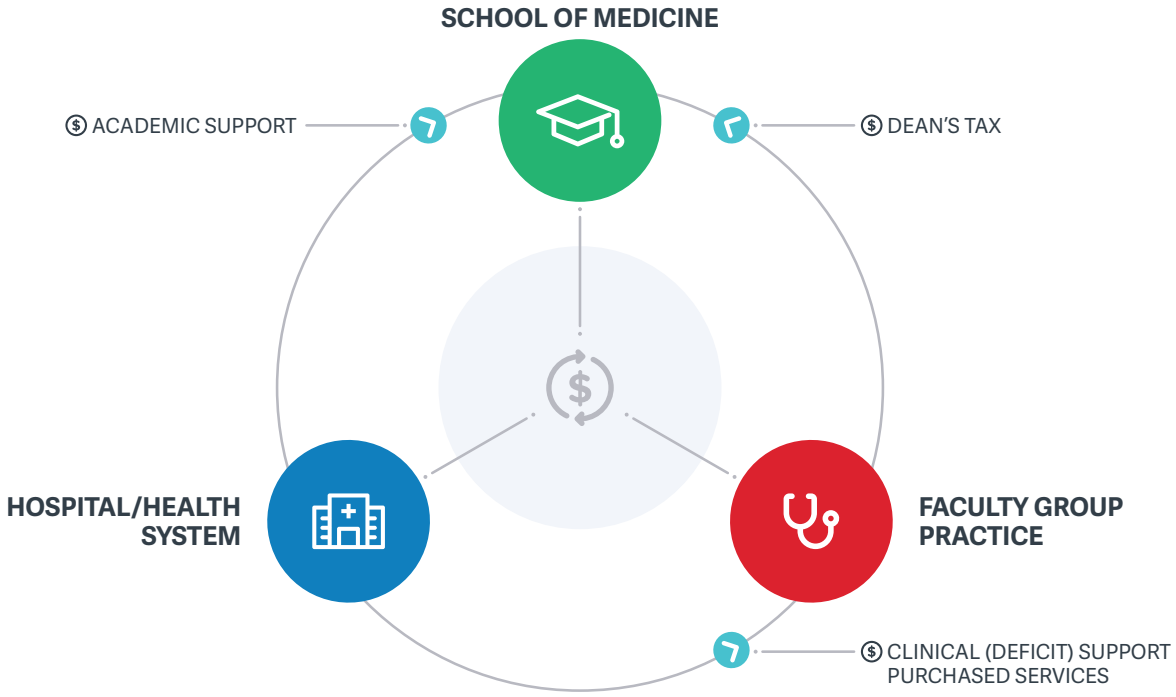
APPROACHES FOR ACADEMIC HEALTH SYSTEMS

ECG MANAGEMENT CONSULTANTS

A Siemens Healthineers Company

As discussed in our article "Is It Time to Abolish the Dean's Tax?," schools of medicine (SOMs) have often applied a top-line professional revenue tax—the dean's tax—to provide an additional source of funding to the academic enterprise. This approach is proving to be outdated, as market forces are driving increased financial integration of the AMC component entities (SOMs, health systems, and faculty group practices). Recognizing the need for continued reinvestment in the academic enterprise and alignment between affiliates, forward-thinking AMCs are eliminating the dean's tax and revising historical financial arrangements. These arrangements are disproportionately funded by the health system and are often partially circular in nature, as the dean's tax may cause or increase a clinical operating deficit of the faculty group practice, as depicted in figure 1.

Figure 1: Illustrative Historical Financial Arrangements



Revisiting these arrangements provides an opportunity to:

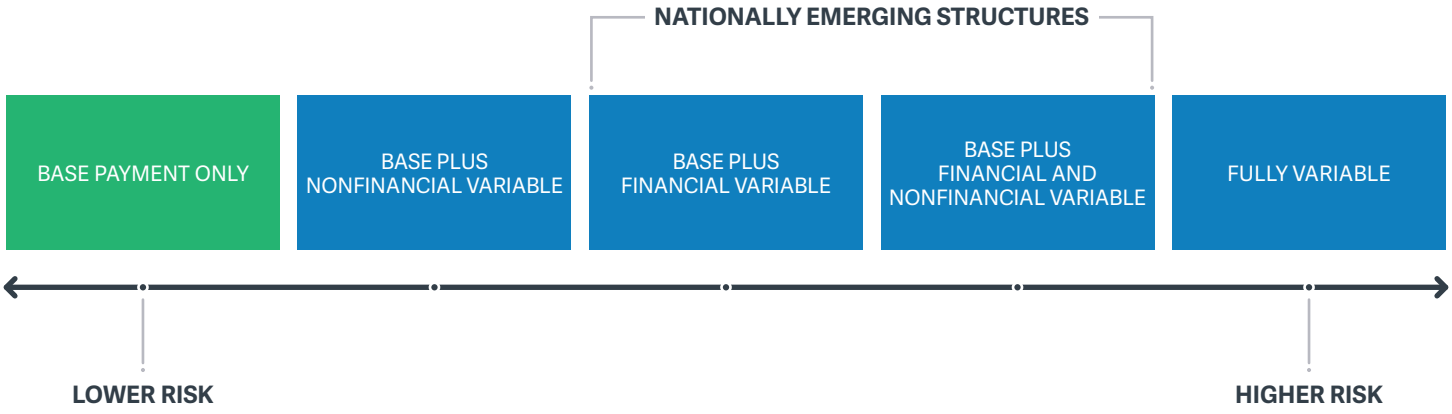
- Reduce or eliminate long-standing backstop-based funding to clinical departments.
- Promote financial sustainability and transparency.
- Simplify contractual negotiations.
- Reduce administrative burden.
- Facilitate greater financial integration among the component entities.

Institutions seeking to eliminate legacy financial arrangements and modernize the overall approach to academic investment should consider a range of approaches, factors impacting their design, and best practices for the financial relationship.

A MODERN APPROACH: INCORPORATING SHARED RISK AND REWARD

Progressive AMCs are developing mission support approaches that link academic funding to health system performance, better aligning incentives across the collective enterprise. These contemporary approaches encourage collaboration to improve and sustain successful enterprise-wide performance while promoting shared goals among stakeholders across the tripartite mission. There is a spectrum of possible arrangements that introduce varying levels of risk to funding amounts supporting the academic mission; the full range is depicted in figure 2.

Figure 2: Range of Mission Support Payment Structures



Determining the relative weighting of base and variable components, as well as the variable metric(s) chosen, is specific to each AMC and generally dependent on historical working relationships between organizational leaders. Entities with a high level of trust may be more risk tolerant, while those with more complex working relationships may prefer lower levels of mutual risk and reward.

BASE COMPONENT

The base component is a predetermined (e.g., set annually) amount of funding that provides a predictable and budgeted amount of support to the SOM. This amount should be sufficient for the SOM to maintain high-quality academic operations while incentivizing the optimization of resources and careful financial management. This component often replaces legacy academic taxes on clinical revenue (such as the dean's tax) that support the academic enterprise.

VARIABLE COMPONENT

Variable funding may be linked to both financial and nonfinancial metrics. These metrics are used not only to inform a threshold that will "trigger" the release of a variable component payment but often serve to inform the calculation of the payment itself. Health system operating margin exceeding a predetermined threshold is the prevailing financial metric emerging in the market for triggering and calculating a variable payment. This metric supports financial sustainability for the clinical partner while positioning the faculty group practice as a strategic health system partner to maximize revenue generation, implement cost reductions, and support other health system initiatives. Organizations may also opt for a percentage of net patient services revenue, which recognizes faculty involvement in revenue enhancement opportunities (e.g., charge capture) but does not incentivize or otherwise promote expense management. Although there is increasing interest in incorporating nonfinancial metrics such as clinical quality measures, organizations generally select financial metrics due to their connection to health system financial performance. An illustrative list of variable component metrics is shown below in table 1.

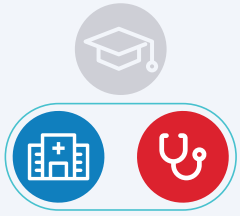
Table 1: Example Variable Metrics

FINANCIAL	NONFINANCIAL
■ Net patient services revenue	■ Market share increase/volume growth
■ Operating margin	■ Quality metrics (e.g., readmission reductions)
■ Net income	■ Strategic initiatives (e.g., new program development)
■ Revenue or net income growth (above a predefined baseline)	■ Patient experience metrics (e.g., HCAHPS scores)
■ Expense savings and reductions	

MISSION SUPPORT ARRANGEMENT EXAMPLES

Mission support models vary widely depending on organizational structure, financial position, degree of base and variable funding desired, and other factors. Figure 3 outlines select mission support arrangements currently in practice at leading AMCs across the country. Each arrangement has been informed by the individual characteristics and circumstances of the component entities.

Figure 3: Mission Support Structures

	ENTITY ONE	ENTITY TWO	ENTITY THREE
REGION	Northeast	Midwest	Southeast
OWNERSHIP	Public	Public	Private
STRUCTURE			
ARRANGEMENT SUMMARY	■ Base payment, subject to adjustment of the faculty group practice's annual gain or loss ■ Variable payment if health system achieves 3% operating margin ■ Tiered approach in which the SOM receives a larger variable payment if the operating margin increases above defined thresholds	■ Base payment, generally determined using historical academic funding levels ■ Variable payment triggered when the health system margin exceeds the Standard & Poor's median value ■ Variable payment that is calculated as a percentage of net patient services revenue, in which the percentage increases as margin increases	■ Base payment, which increases annually in accordance with the Biomedical Research and Development Price Index ■ "Royalty" component, equal to 1% of annual health system operating revenue, for use of university brand/trademarks ■ Additional variable component as a percentage of health system net operating income (increasing up to 15%)

Hospital/Health System School of Medicine Faculty Group Practice

BEST PRACTICE CONSIDERATIONS

Parties exploring a contemporary mission support arrangement should consider the following best practice considerations and success factors during the design and implementation phases. These considerations are based on market trends and industry experience and will enable successful negotiations and ongoing management of the financial relationship, as outlined on the following page.

1

DESIGN A FLEXIBLE ARRANGEMENT

The framework of the arrangement should be able to adapt to changes in the external environment and address how future growth within the health system (e.g., hospital acquisitions) or SOM will impact mission support funding. Institutions may agree to include an automatic inflation adjustment to the arrangement pegged to a nationally recognized benchmark (e.g., Higher Education Price Index).

2

MEASURE PERFORMANCE CONSISTENTLY

Given the importance of key financial and nonfinancial indicators in determining mission support funding levels, definitions for key terms such as net patient services revenue and operating margin must be agreed upon prior to implementation and monitored routinely (e.g., no less than quarterly) in a transparent manner. This will create consistency in year-over-year calculations and promote transparency among all stakeholders.

3

EVALUATE HISTORICAL FUNDING LEVELS

A redesign of the mission support arrangement should assess existing funding levels from the clinical enterprise to ensure rationalized support moving forward. In select instances, it may be appropriate to recalibrate and reduce funding from historical levels. Some organizations implement a "do no harm" approach that does not reduce existing levels of financial investment from the clinical enterprise (i.e., the dean's tax and discretionary investment).

4

PROVIDE OVERSIGHT OF FUND DISTRIBUTION

Guidelines for fund distribution should be defined to facilitate alignment with joint organizational initiatives and goals. The clinical partner and SOM may also elect to collaboratively identify and monitor return-on-investment metrics. Adequate oversight will also ensure commercial reasonableness of the arrangement and mitigate concerns regarding possible Anti-Kickback Statute violations.

5

INCLUDE FINANCIAL PROTECTIONS

Appropriate provisions, such as a financial exigency clause, should be included to protect the clinical enterprise and SOM in the event of a material and unavoidable deterioration in either entity's financial position. This may include the suspension or reduction of mission support funding in the event of health system strain or additional funding in the event of SOM challenges. Exigency terms should be applicable only in limited and well-defined circumstances.

THE TIME IS NOW FOR MISSION SUPPORT REEVALUATION

As the healthcare market continues to evolve and AMC component entities collectively face increasingly challenging financial circumstances, health systems and schools of medicine are creating new financial arrangements or amending existing approaches documented in long-term affiliation agreements to reflect the current market landscape. Modern arrangements successfully align incentives between the component entities and allow the clinical partner to purposefully invest in the academic enterprise in a sustainable and transparent manner. Those that continue to rely on antiquated funding structures such as the dean's tax and other legacy financial arrangements are poorly positioned to optimize increasingly scarce resources or react to ever-dynamic market pressures.

If your organization is relying on an outdated funding structure, now is the time to modernize your approach to investment in the academic mission.

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the Authors

NEELAM PATEL
Senior Manager
npatel@ecgmc.com

THOMAS FLEMING
Manager
tfleming@ecgmc.com

A Siemens Healthineers Company