



A SERVICE OF
nrc
HEALTH

Academic Health Focus



March 2018

Finding Balance in Teaching Hospital–Medical School Partnerships

By Christopher T. Collins, Principal, ECG Management Consultants, and Eb LeMaster, Managing Director, Ponder & Co.

In 1981, the average medical school received less than 7 percent of its total funding from its affiliated teaching hospitals.¹ This percentage has grown year over year and, in 2017, exceeded 18 percent.² Why have medical schools become more dependent on funding from teaching hospitals? Because all other funding sources have flattened or declined, while maintaining competitive academic programs has only become more expensive. Research loses on average are 40 cents to every dollar. At best, medical education (i.e., tuition and fees) breaks even once all overhead is considered. Faculty group practices were once a reliable source of cross-subsidization for medical schools (i.e., “dean’s tax”), but freestanding faculty group practices are generally no longer self-sufficient due to a steady decline in professional fee reimbursement.

This leads us to the teaching hospital. The average U.S. non-federal teaching hospital has an operating margin of 4.5 percent, average days cash on hand of 125, and instability with respect to common reimbursement advantages (e.g., the 340B program).³ This has resulted in major teaching hospitals being more judicious regarding investments in the academic enterprise at a time when medical schools are looking for additional funding to sustain their three-part mission. Further exacerbating this issue, there has been significant alignment in recent years between academic medical centers (AMCs) and community hospital systems. As this consolidation further accelerates, the two sides are now forced to develop models and governance structures that are acceptable to both and require meaningful compromise.

¹ Association of American Medical Colleges, *AAMC Data Book: Revenues for the General Operational Programs of U.S. Medical Schools*, May 1990.

² Association of American Medical Colleges, *AAMC Data Book: All U.S. Accredited Medical School Revenue by Type, \$ in Millions*, 2017.

³ Hospital financial and operating metrics reported by Optum360.

Key Board Takeaways

When it comes to partnerships between teaching hospitals and medical schools, boards should recognize and consider the following:

- Health systems are the economic engines for AMCs in today’s market.
- Integrated academic health systems are currently the market leaders.
- Non-clinical funding streams into medical schools are declining.
- Health systems and medical schools need to compromise and find middle ground when forming partnerships.
- No AMC is actively trying to build a fragmented academic health system.
- Boards need to push leadership to do what is in the best interest of the partnership.
- Parties should state what is “on and off the table” at the outset.

What Major Teaching Hospitals Want

In this highly competitive and ever-changing healthcare market, teaching hospitals are seeking leaner cost structures and more integrated/employed physician models, and they are looking to maximize revenue as collective “health systems.” Consistent with transactions in recent years, such as Vanderbilt University Medical Center’s spin-off, Banner Health’s merger with University of Arizona, and the formation of Northwestern Medicine, a more unified approach is required to deliver healthcare as an academic health system, whereby the teaching hospital and healthcare professionals (clinical full-time

equivalent [CFTE] of faculty, employed non-faculty physicians, and other associate providers) are working together to deliver cost-efficient, high-quality care in patient-centric environments.

To that end, it is common in today's market for teaching hospitals/health systems to want the following with respect to a new affiliation or partnership:

- Representation on the faculty group practice board and/or "health affairs" committee of the university
- Shared approval of chair/chief or major director hiring
- Option to recruit/retain full-time clinicians with or without faculty appointment for certain programs
- Formulaic approach to supporting graduate medical education (GME)/residency programs
- Incentive-based mission support (i.e., not all fixed) linked to hospital performance that is well defined and financially feasible
- Arrangements with medical schools exempt from "assessments" that cannot be linked to actual costs
- Ability to engage in joint payer contracting with faculty practice
- Consistently defined clinical effort of faculty (i.e., CFTE)
- Ability to measure tangible and intangible ROI for investments made in GME and research program development
- Medical school's understanding of the financial position of the hospital, including calls for capital investments and the need to maintain a certain bond rating for borrowing power

What Medical Schools Want

Without the elements of medical education and research, an AMC becomes a community hospital/health system. Financial pressure is mounting on hospitals, so it is understandable if affiliated medical schools grow wary of whether teaching hospitals will maintain the needed balance with the academic mission. Recruitment and retention of high-caliber faculty is essential to thrive and to sustain a three-part mission. Demands for high clinical productivity from the faculty group practice and/or the teaching hospital can divert time and attention away from medical education and research. Moreover, the market is calling for faculty practices to become more financially aligned with teaching hospitals, which

has played out with their non-academic counterparts. The number of physicians employed by a hospital or hospital-controlled group has surged from 27 percent in 2006 to 79 percent in 2016.⁴ This trend of hospital-physician integration is occurring in academic medicine and can concern medical schools regarding the actual or perceived lack of control of clinical faculty.

With that backdrop in mind, the following are examples of what medical schools are seeking in an affiliation/partnership with a major teaching hospital:

- Teaching hospital CEOs who have experience in and embrace the three-part mission of AMCs
- Representation on the hospital board
- Commitment that the academic chair will dually serve as hospital chief of service
- Reliable financial support of clinical programs that are essential for maintaining accreditation but are likely not self-sufficient (e.g., psychiatry)
- Steady support of GME supervision and administration—regardless of cap and independent of direct medical education (DME) and indirect medical education (IME) funding
- Exclusivity for the provision of professional services by faculty, wherever possible
- Dyad management structure where physician leaders' input is valued
- An annual source of base funding from the teaching hospital that can be used at the discretion of the dean for investment in the academic enterprise

Finding a Middle Ground

University and teaching hospital/health system boards and senior leadership should first and foremost focus on establishing a shared vision, with a full understanding of how the partnership will advance the mission spanning both organizations. Too often the dialogue focuses prematurely on finances and board seats. As part of the process to outline the mutually desired relationship, the parties should clearly define the "roles" of each entity within the context of an AMC, including lead roles for clinical enterprise,

⁴ Derived from Medical Group Management Association (MGMA), *Physician Compensation and Production Survey: 2007 Report Based on 2006 Data*, and MGMA *2017 Provider Compensation and Provider Report*.

GME, and research. As mentioned, market forces have prompted highly integrated health systems, which can raise concerns for medical school deans regarding the control of the clinical enterprise. This topic needs to be addressed early in the process. The parties should recognize that compromises and trade-offs will need be made.

Below are a few examples of key middle-ground terms in more recent and contemporary partnerships between medical schools and major teaching hospitals (i.e., major affiliation agreements).

- Cross-representation on respective boards
- Bidirectional input or approval for senior executive (e.g., dean, hospital CEO)
- Commitment to exclusivity
- Agreement to embrace physician leadership throughout the system, including input into major operational and financial decisions

- Mission support payments (discretionary) is linked to teaching hospital financial performance
- Integrated physician enterprise (health system employees or contracted), but with certain protections/rights of medical school to ensure clinical obligations do not adversely impact academic duties

Partnerships between medical schools and major teaching hospitals have become increasingly complex, risky, and expensive, with very little room for error. Boards and senior leaders will need to invest significant time and focus to protect the interests of their organizations as they enter these 20- to 30-year affiliations in a sector that may have the highest-possible degree of uncertainty of any U.S. sector.

The Governance Institute thanks Christopher T. Collins, Principal, ECG Management Consultants, and Eb LeMaster, Managing Director, Ponder & Co., for contributing this article. They can be reached at ccollins@ecgmc.com and elemaster@ponderco.com.

