

An HFMA Value Project Report

Acquisition and Affiliation Strategies



hfma

healthcare financial management association

ABOUT THIS REPORT

The findings in this report are based on:

- Responses (145 total) to an HFMA survey sent to a random selection of senior financial executive HFMA members in October 2013. Fifty percent of respondents represented stand-alone hospitals, and 50 percent represented systems (20 percent at the system headquarters level and 30 percent at the system facility level).
- Site visits and interviews with the following hospitals and health systems:
 - AllSpire Health Partners member organizations (Pennsylvania and New Jersey)
 - Dignity Health (multistate, California headquarters)
 - Froedtert Health (Milwaukee metropolitan area)
 - HealthPartners (Minneapolis-St. Paul metropolitan area and western Wisconsin)
 - NewYork – Presbyterian Hospital (New York metropolitan area)
 - North Shore – LIJ Health System (New York metropolitan area)
 - SSM Health Care (Illinois, Missouri, Oklahoma, and Wisconsin)
- Interviews with strategic consultants, finance executives, and legal and regulatory experts quoted in this report.

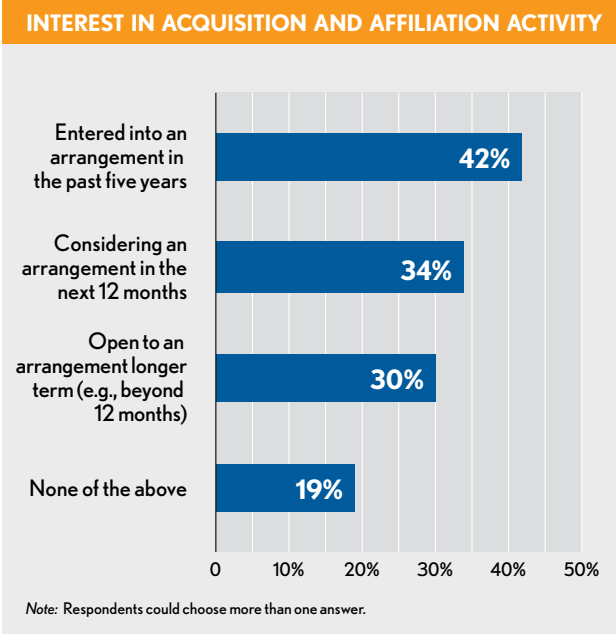
INTRODUCTION

The demands of today’s healthcare marketplace are spurring a new wave of acquisitions and affiliations among healthcare organizations. Facing pressure to reduce the cost of care, improve the coordination of care delivery, and assume financial risk for the health outcomes of patient populations, organizations are seeking partners who can help them add new capabilities, achieve economies of scale, enrich data on clinical outcomes, or widen access to services.

A survey of HFMA’s senior financial executive members, conducted in the fall of 2013, indicates the extent of interest in acquisition and affiliation activity. More than 80 percent of respondents had entered into an arrangement or were actively considering or open to the idea.

Although the acquisition and affiliation strategies discussed in this report are part of a wider trend toward consolidation, this report’s emphasis will be squarely on *value-focused* acquisition and affiliation strategies. Consolidation efforts that are focused primarily on gaining market dominance are less likely to increase the value of care for patients and other care purchasers, and are more likely to attract unfavorable scrutiny from employers, health plans, other competitors, the media, and potentially state and federal antitrust authorities. On the other hand,

acquisition and affiliation strategies designed to improve the quality or cost-effectiveness of care are more likely to deliver value to care purchasers, demonstrate an organization’s superior value proposition in a competitive marketplace, and accordingly improve that organization’s market share.



RESEARCH HIGHLIGHTS

Several key themes emerged over the course of our research on acquisition and affiliation strategies.

An emphasis on value-focused strategies. The healthcare organizations interviewed for this report understand that the best way to gain market share is by meeting care purchasers’ demand for high quality, convenient access, and competitive prices. They are seeking acquisition and affiliation partners that will help them achieve these goals.

An understanding that different needs require different approaches. Organizational needs vary greatly depending on local market conditions and the organization’s mission, existing capabilities, and future goals. Organizations are considering a range of partners and partnership opportunities to meet these needs, often pursuing several options simultaneously.

The emergence of new organizational combinations. Healthcare organizations are growing both horizontally (e.g., hospital to hospital) and vertically (e.g., healthcare system to health plan), and different types of organizations are combining forces (e.g., academic medical centers and regional health systems).

A blurring of the lines between competition and collaboration. Market conditions and organizational needs are opening up collaborative possibilities for organizations that may have viewed one another as competitors.

The need to change governance and support structures as organizations change. As organizations grow and gain new capabilities, they are reevaluating and reshaping existing board and management structures, IT systems, financial systems and fund-flow models, and physician relationships to accommodate the changes.

DRIVERS OF ACQUISITION AND AFFILIATION STRATEGY

Traditional acquisition activity—in which a weaker system, typically seeking capital investment, is acquired by a stronger system—continues in the healthcare industry. However, many arrangements are being driven more by strategy than by financial need. “Around 2009, we saw the rationale for acquisition and affiliation activity change,” says Kit Kamholz, managing director at Kaufman Hall. “Organizations became more interested in bolstering their physician platforms, driving quality initiatives, lowering costs, improving IT foundations, and enhancing their brand.”

“A trend now is that mergers and acquisitions are occurring between organizations that are both financially strong,” says Jullia Quazi, managing director at BMO Capital Markets. “This is different even from the recent past, when traditionally one party to the transaction had significant financial concerns.”

Interviews with acquisition and affiliation consultants and provider organizations that are actively pursuing acquisition and affiliation strategies identified several key drivers of activity in today’s marketplace.

OPERATIONAL EFFICIENCIES

Organizations recognize the need to achieve greater economies of scale in purchasing and to centralize and streamline operational functions such as revenue cycle or IT. AllSpire Health Partners, a collaborative partnership of seven independent health systems representing 25 hospitals in New Jersey and Pennsylvania, arose from conversations among CEOs of the participating systems, “each of whom was looking for as many ways as possible to add scale,” says Marion McGowan, executive vice president and chief population health officer at Lancaster General Health, one of the systems in the alliance. “They were seeking a way to remain independent, yet achieve economies in partnership with others that they would be unable to achieve on their own.”

CLINICALLY INTEGRATED CARE DELIVERY NETWORKS

Hospitals, health systems, physician practices, and other providers may seek to create clinically integrated care delivery networks that will provide convenient access to high-quality services at competitive prices and can be marketed to health plans, employers, and individual consumers. The 2013 combination of HealthPartners and Park Nicollet Health Services in the Minneapolis-St. Paul market, for example, “completes the geography for a combined entity with a ‘shared DNA’ of careful stewardship of community resources to compete across the entire metropolitan area with a system emphasizing primary and specialty care services in clinics and ambulatory settings,” says Nance McClure, HealthPartners’ COO.

POPULATION HEALTH MANAGEMENT

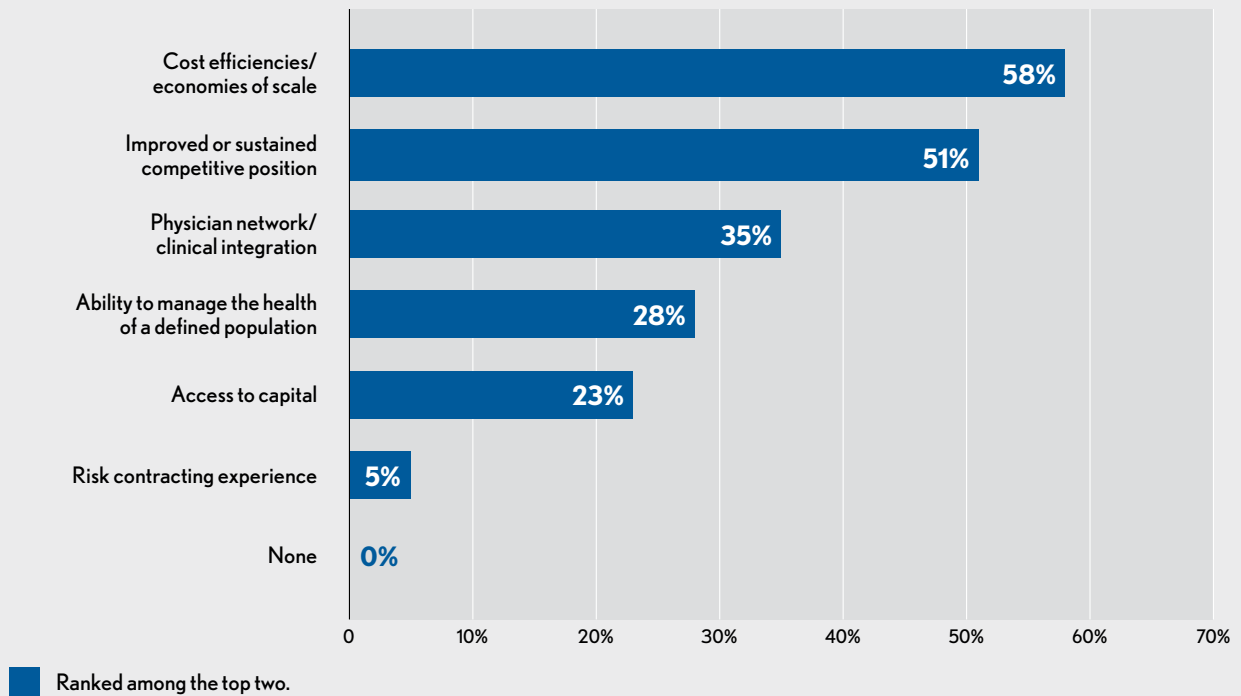
Many organizations see inevitable—and potentially rapid—movement toward a system in which providers will be asked to assume financial risk for managing the health of a defined population. They need access to data on populations of a sufficient size to help identify appropriate risk corridors and drivers of utilization and cost in various patient subpopulations.

NEW CAPABILITIES

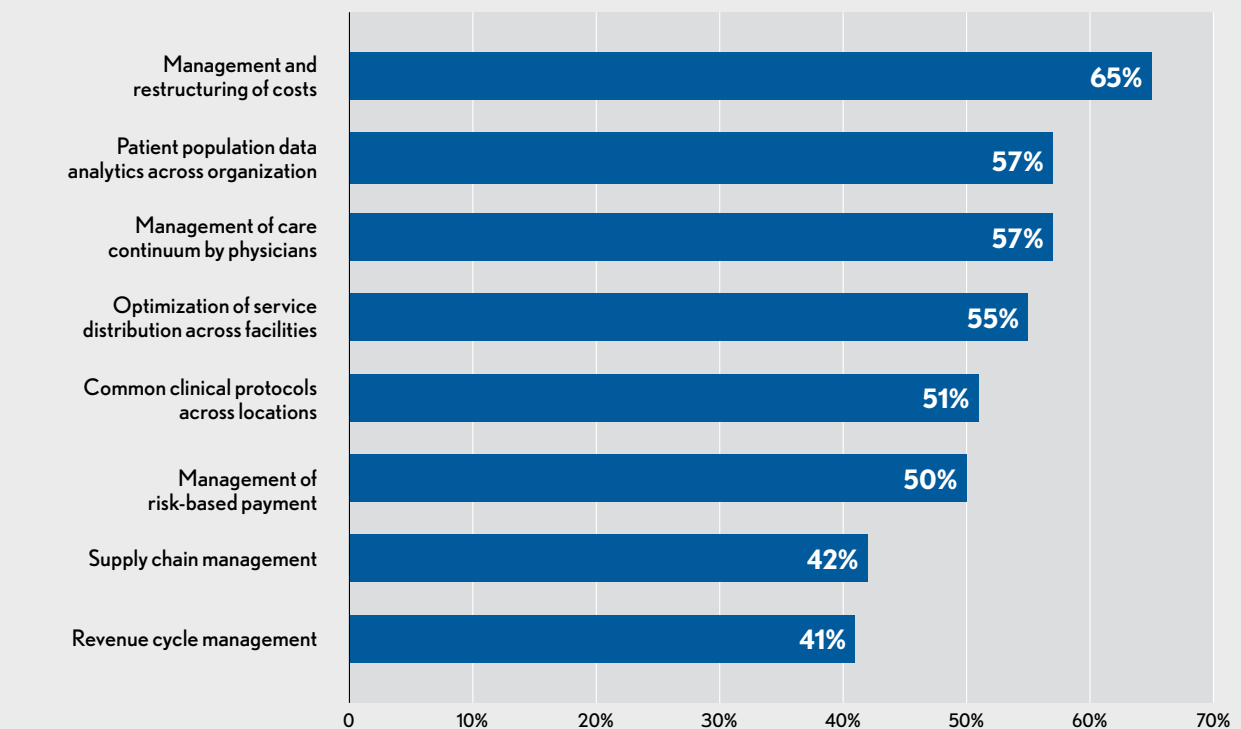
Although many capabilities can be developed internally, acquiring or affiliating with a partner that has developed key capabilities can be more efficient. For example, St. Louis-based SSM Health Care recently acquired Dean Health, a large, for-profit, multispecialty physician group that includes a health plan and is located in south-central Wisconsin. “When Dean put itself on the market, we saw a strategic opportunity to utilize Dean’s capabilities in managing physicians and running a health plan to further SSM’s transformation to an integrated, value-based organization,” says Gaurov Dayal, MD, president of healthcare delivery, finance, and integration for SSM Health Care.

DRIVERS OF ACQUISITION AND AFFILIATION ACTIVITY

What are the most important reasons for an organization to consider a new organizational arrangement?



EXPECTED IMPROVEMENT IN CAPABILITIES BY ACQUISITION OR AFFILIATION



SERVICE LINE OR ASSET RATIONALIZATION

“The right care at the right time in the right place” has become a mantra in health care, but putting these words into action may cause significant disruptions to the existing infrastructure. Changes in utilization patterns and sites of care likely will require some level of coordination among health systems in the market to “right-size” the system in a way that maintains affordable access to care. “In markets with excess capacity, there will be a need to rationalize services and reduce beds,” says David Johnson, former sector head and managing director at BMO Capital Markets. “There has to be a framework to tackle these types of questions.”

HFMA’s survey of senior financial executive members regarding their acquisition and affiliation activities reflected these concerns. Members identified the need to improve cost efficiencies and economies of scale as the strongest driver of acquisition and affiliation activity (see the exhibit at the top of page 3). Improved economies of scale were of particular importance for respondents in stand-alone facilities: 68 percent of respondents in such hospitals ranked this concern among their top two, compared with 58 percent of all respondents.

When asked what capabilities they would hope to improve through affiliation and acquisition activity, more than half the respondents identified:

- Restructuring of costs
- Improved access to patient population data analytics
- Cross-continuum management of care by physicians
- Optimization of service distribution across facilities
- Creation of common clinical protocols across locations
- Management of risk-based payment

As the responses suggest, the drivers of acquisition and affiliation activity today are multiple and diverse. These needs will be dictated by a variety of factors, including local market conditions, organization type, and existing and desired organizational capabilities. Few organizations should aspire to be all things to all sectors of their market. Some are well-situated as they are and have no immediate need to consider a change in structure, but many feel pressure from some or most of these drivers. As discussed in the following section, numerous acquisition and affiliation options are available to meet the varying needs of organizations.

ACQUISITION AND AFFILIATION OPTIONS

Almost 20 years ago, during the era of managed-care innovation, Robert Pitofsky, then chair of the Federal Trade Commission (FTC), suggested that as “pressures to control healthcare costs and assure quality continue, there is an increasing recognition of the efficiencies that can come about through cooperation and collaboration.”^a

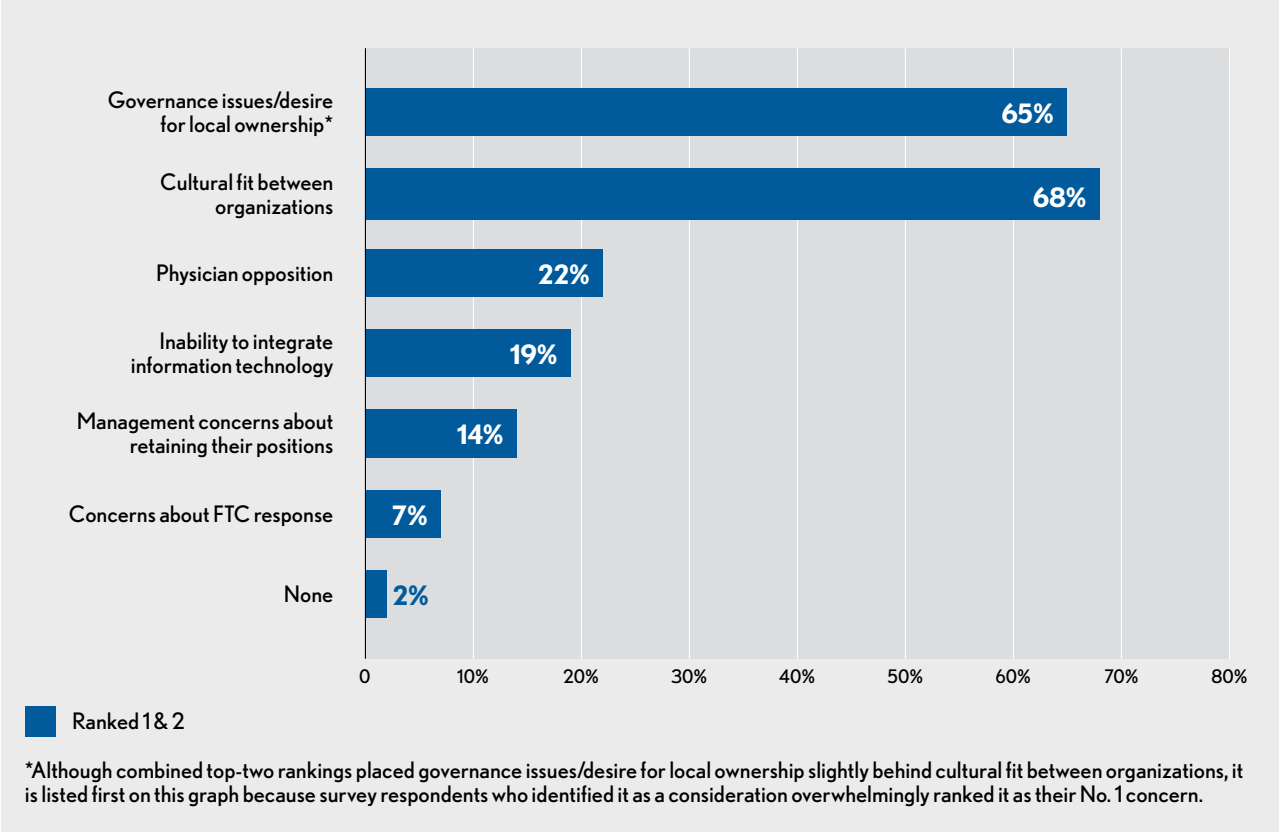
Backlash against the managed-care movement slowed the new models of cooperation and collaboration that Pitofsky discussed in his 1997 speech, although merger-and-acquisition activity continued. But with a renewed emphasis on value—with “pressures to control healthcare costs and assure quality” only growing more acute—various acquisition and affiliation models to increase cooperation and collaboration have emerged and continue to develop.

Acquisition and affiliation models range from the full merger of two organizations into a single, combined entity

to looser collaborative models in which organizations work together on certain initiatives but maintain freedom to pursue other opportunities individually or in partnership with other organizations. Organizations are looking for partners both horizontally (e.g., hospital to hospital) and vertically (e.g., health system to health plan). Some are pursuing multiple models simultaneously, depending on their organizational needs and the opportunities in their market.

Determining whether to pursue an acquisition or affiliation opportunity—and which model or models to pursue—should begin with an honest assessment of organizational position and anticipated future needs (see the accompanying sidebars). The HFMA survey of senior financial executives indicated areas that merit special consideration when conducting internal organizational assessments and evaluating potential partners.

CONSIDERATIONS BEFORE AGREEING TO ACQUISITION OR AFFILIATION



Internally, if the board or senior leadership team is firmly committed to maintaining local ownership, organizations can consider looser collaborative models in which the partners remain independent. At the same time, the board and leadership team should assess whether maintaining local ownership will best serve long-term organizational needs.

Externally, cultural fit is critical. In many markets, potential partners are familiar with each other and may have worked together already. Still, before finalizing an affiliation agreement, the organizations should have frank discussions about how each hopes to benefit from the relationship and what each would bring to it, and potential obstacles to reaching shared goals.

HORIZONTAL MERGERS, AFFILIATIONS, AND COMBINATIONS

Although traditional merger-and-acquisition activity continues among health systems, the focus of this activity is increasingly strategic. Many acquiring organizations are not interested in adding acute inpatient capacity. Leaders at Dignity Health, which has corporate headquarters in the San Francisco Bay Area, forecast as much as 40 percent excess inpatient capacity in their markets within the next five years. Accordingly, Dignity Health aims to scale back on inpatient beds while considering acquisitions where it has a need for growth or to complement the services it provides in a market. As Peggy Sanborn, Dignity Health’s vice president of partnership integration, notes, “Most hospitals come with other assets, such as a physician network.”

THREE KEY QUESTIONS

Is your hospital or health system wondering whether it should restructure through an acquisition or affiliation? Kit Kamholz, managing director at Kaufman Hall, suggests considering three key questions:

- Can my organization be successful in its current configuration?
- If not, what type of partnership makes the most sense based on critical success factors and organizational goals?
- What partner can best help my organization accomplish its goals?

Robert Shapiro, CFO of North Shore-LIJ Health System, based in Long Island, N.Y., observed that much of the hospital consolidation in the North Shore-LIJ system occurred in the 1990s. The system is preparing for a future in which core activity shifts from the hospitals to the physicians, and is focused on clear strategic opportunities when acquiring hospitals. For example, the acquisition of Lenox Hill Hospital gave North Shore-LIJ a presence in Manhattan.

If the potential acquisition is a hospital-based system, its other assets may be at least as important as the hospital itself. These assets might include affiliated physician networks, outpatient clinics, experience running a health plan, and, more intangibly, a favorable market position and payer mix. Financially troubled hospitals are becoming less attractive, even if they offer advantages such as a strong payer mix or location in a good market, unless opportunities to engineer a financial turnaround are apparent (for example, opportunities through the supply chain).

The distinction between not-for-profit and for-profit status has become less important in the context of acquisition or affiliation. Kaufman Hall’s Kamholz states that hospitals should not focus too much on the tax status of a potential hospital partner. “In terms of forming new structures, the importance of this distinction has diminished over time. For-profit systems have become more experienced with recognizing and accommodating needs of not-for-profit partners, while larger not-for-profit health systems have become more business-focused and centralized in their decision making.” Charlie Francis, chief strategy officer for Dignity Health, agrees: “There is a big difference between how you live out your mission and your tax status.”

Religious affiliations of not-for-profit systems can pose roadblocks in some instances. The ethical and religious directives of Catholic hospitals and systems, for example, may reduce opportunities for partnerships with organizations that provide services in conflict with church teachings. Dignity Health addressed this issue by ending its governing board’s affiliation with the church in January 2012, although the organization remained not-for-profit. The board of directors assumed governance duties for the organization as a whole, while a separate sponsorship council has responsibility for the system’s Catholic facilities.

Case studies: Integrating without merging. Although integration through a merger is the most common type of horizontal transaction, some organizations have pursued models that achieve extensive integration without a full merger.

Froedtert Health and the Medical College of Wisconsin have affiliated to create a system in which they maintain separate boards but utilize an internal joint management structure. A key component is the clinical executive committee, which oversees joint planning, IT governance, and quality performance for the system. A 20-month planning effort also resulted in a new funds-flow model in which a percentage of the system's bottom line goes to the medical college to support academic programs, strategic reserves, joint investments, and a performance fund for the faculty practice.

This combination of an academic medical center with a regional health system provides opportunities to shift care, moving lower-acuity procedures to Milwaukee-based Froedtert's community hospitals and freeing capacity to treat higher-acuity cases at the Froedtert Hospital, the academic medical center. Froedtert Hospital runs at approximately 85 percent capacity, with delays of up to 30 days to get an appointment on the campus. "Most academic medical centers do a lot of 'commodity' care, which is good for both training programs and revenue," says Mark Lodes, MD, president of Community Physicians, a joint venture that combines Froedtert's employed and affiliated community physicians with faculty physicians who also practice in the community. "But we need to ensure that the right types of services are provided on the academic medical center campus and in the community hospitals."

Accordingly, Froedtert and the Medical College are moving elective joint surgeries off the main campus to Community Memorial Hospital, a facility located 14 miles away, using a "focused-factory" concept.

The decision was influenced by several factors. The community hospital had both capacity and high-quality outcomes. The procedure and population are well-defined, and the population is willing to travel for the procedure. And the cost of performing the procedures at Community Memorial will be significantly less than at Froedtert Hospital, allowing the system to promote Community Memorial as a lower-cost, high-quality center of excellence

with which payers will want to contract. This frees up much-needed capacity at Froedtert Hospital for higher-acuity cases.

The effort also is forging closer relationships between community physicians and faculty physicians. "There was not much of a relationship between the community and academic physicians before this initiative," Lodes says. "This is changing that situation. The conversation today is about what it takes to run a center of excellence at Community Memorial."

HealthPartners and Park Nicollet Health Services came together in 2013 in what they describe as a combination, not a merger. Minnesota-based HealthPartners consistently has pursued a combination strategy in lieu of a buy-out model in its affiliations, limiting capital spending primarily to investments in new partners' electronic health record (EHR) systems or commitments to specific needs over a defined time frame.

In addition to Park Nicollet, Health Partners in recent years has combined with Lakeview Health, which includes the Stillwater Medical Group and Lakeview Hospital in Stillwater, Minn., approximately 20 miles east of St. Paul on the Minnesota/Wisconsin border; and several smaller hospitals—including Amery Regional Medical Center, Hudson Hospital & Clinics, and Westfields Hospital—that are part of the Twin Cities metropolitan area in western Wisconsin. HealthPartners also owns Regions Hospital, formerly Ramsey County Hospital, which it acquired in 1994.

SETTING A FUTURE COURSE

Jullia Quazi, BMO Capital Market's managing director, and David Johnson, BMO's former sector head and managing director, suggest organizations use the following questions to assess their position and chart a course toward possible acquisition or affiliation:

- What business or businesses am I in?
- What is the growth trajectory for my business, and how can I best invest in areas with the highest growth potential?
- Do I have the right executive team and governance structure in place to effectively position my organization for the future? If not, what types of people do I need?
- What forms of affiliation should we consider?
- What can we stop owning and instead obtain through partnership or outsourcing?

The organizations are under the oversight of a 19-member, consumer-governed board of directors (the Wisconsin hospitals still maintain local boards, with reserve powers for the organization board). They remain distinct corporate entities, however, with separate budgetary and margin goals. HealthPartners and Park Nicollet also maintain separate contracting relationships with payers, including different fee schedules and different relationships with payers in the market. In interviews, HealthPartners leaders describe the combined organization's corporate structure as "a unifying culture working for results driven by the Triple Aim [of improving care experiences, improving the health of populations, and lowering costs], with variations in the care delivery structure." The organization is highly matrixed across its component parts: McClure, the HealthPartners

COO, noted that a traditional organizational chart "would be largely irrelevant."

Because the combined organizations within HealthPartners are separate entities, an emphasis on streamlining operational efficiencies has been less emphasized than in many horizontal combinations. The combined system has achieved economies of scale in its supply chain and has merged legal-and-compliance and marketing-and-communications functions on the operational side. (As separate employers, the entities maintain separate human resource departments.)

Much more significant is HealthPartners' blueprint on the clinical side, particularly its use of data analytics to increase value (by improving quality and managing the total cost of care) across the combined system. Park Nicollet and HealthPartners purchased an EHR system from the same

FACTORING IN ORGANIZATIONAL TYPE

In Phase 2 of the Value Project, HFMA researched the impact of the transition to value on five organizational types: aligned integrated systems, academic medical centers, multihospital systems, rural hospitals, and stand-alone hospitals. Although acquisition and affiliation strategy will be driven by multiple factors, here are specific considerations for each type:

ALIGNED INTEGRATED SYSTEMS

Many of these organizations developed from a multispecialty clinic and include a health plan. They face unique challenges in adapting their tightly integrated models—which in many instances have evolved over the course of decades—to new partners.

The culture of a potential affiliate is important regardless of organizational type but particularly is significant for aligned integrated systems. Is the potential partner open to cultural change? How well-aligned are the partner's physician practices to overall organizational goals? Have the partner's physicians, either independent or employed, demonstrated an ability to collaborate effectively on clinical improvement initiatives?

ACADEMIC MEDICAL CENTERS

To fully support their threefold mission of teaching, research, and specialized clinical care, academic medical centers need access to larger populations than do other hospitals. At the same time, most centers have strong reputations and brands that they understandably want to maintain.

Academic medical centers are pursuing a variety of acquisition and affiliation strategies to gain access to a population large enough to support their mission, with a target population of 3 million cited by representatives of various academic medical centers during interviews for this report. Some have affiliated with a regional health system in their market, strengthening community hospitals in the system through improved access to the expertise of the medical faculty while bolstering the academic medical center through referral networks for tertiary and quaternary care. Others are using telehealth strategies to reach suburban and rural populations, potentially allowing the partner organization to stabilize and retain the patient onsite, and making the academic medical center a logical destination for a referral if a patient needs to be transferred.

With respect to their brand, academic medical centers have a keen interest in the reputation and quality of potential partners. For example, as New York-Presbyterian Hospital considers tightening its affiliations with nonacademic partners, "Our aim is coverage in the market, not size for size's sake," says Phyllis Lantos, the hospital's CFO. "We want the best in each community."

MULTIHOSPITAL SYSTEMS

Many multihospital systems interviewed for this research noted the importance of ranking among the top two systems in their market to offer the most attractive and competitive network products to care purchasers.

vendor but have been on different instances of that system. An immediate emphasis is on getting all entities on the same instance of the EHR, as well as on the same financial management system.

The combination of HealthPartners and Park Nicollet has the potential to be a “game changer” because the combined entity is able to compete across the entire Twin Cities metropolitan area and has access to clinical data on a combined patient population of approximately 1 million. Among other factors working in its favor: It brings together key specialty focuses, with the ability to develop deeper subspecialization across the larger patient base. And it creates a system that is relatively light on hospital beds, with an emphasis instead on primary and specialty care services in clinics and ambulatory settings.

HealthPartners’ ability to utilize data analytics to achieve Triple Aim goals has been demonstrated by tools the system has developed to reduce total cost of care within its own care delivery network and, as a health plan, with other providers across the state. In 2007, for example, HealthPartners developed a point-of-order decision support tool that could be embedded in EHR systems and offered the tool for use to all healthcare systems in the state (part of a multi-payer initiative to reduce the use and cost of high-tech diagnostic imaging). The decision support tool collects information submitted by a clinician during the ordering process and, based on indications from the patient assessment, feeds back a utility score for imaging ranging from 1 (low) to 9 (high). The clinician can still order imaging when the utility score is low, but the tool

Larger systems also should consider seeking scale through geographic breadth or by gaining economies within more regional or local markets. “Large systems can achieve great national economies in such areas as revenue-cycle management, IT, and supply chain,” says Kit Kamholz, managing director at Kaufman Hall. “The question is whether they can also generate regional economies, such as the ability to work effectively with physicians, optimize and rationalize services across locations within a regional market, or share nursing staff to adjust to fluctuations in volume.”

As systems grow, “They can also face a tension between economies of scale and diseconomies of growing complexity in certain relationships,” says David Johnson, former sector head and managing director at BMO Capital Markets. “Some organizations are getting bigger by doing more of what they’ve always done, adding size without increasing complexity. Other organizations are diversifying their organizations as they grow, which increases complexity.”

RURAL HOSPITALS

Rural hospitals in geographically isolated communities face a variety of challenges, including physician recruitment, managing cost structure—sometimes in an environment of declining revenues—and implementing new IT systems. At the same time, the close connection between a rural hospital and its community can make board members reluctant to cede local control.

Affiliations can help rural facilities support specialty services within their community, gain financial support and technical expertise for implementation of electronic health record systems and data analytics, and share in economies of scale to produce better cost-efficiencies. Looser affiliation strategies, such as participation in a telehealth network with a larger system or academic medical center, can support local physicians and keep the care of lower-acuity patients close to home. Tighter affiliation strategies, such as a merger with a larger system, typically provide greater support for operational and IT needs.

STAND-ALONE HOSPITALS

Stand-alone hospitals in competitive markets probably are aware of acquisition and affiliation activity drivers that involve issues of size and scale. Some degree of affiliation activity likely will be necessary for these hospitals to remain competitive.

The primary question is the extent to which stand-alone hospitals want to remain independent. The collaborative partnership models that are emerging in markets around the country, as described in this report, are among the affiliation options that offer opportunities to achieve the benefits of greater size and scale without yielding organizational independence. Whether a stand-alone hospital wishes to remain independent or join a larger system, considerations such as the hospital’s market position, financial strength, and physician relationships will have a significant effect on its options.

also provides alternatives of higher utility (such as ultrasound, plain x-ray, or no imaging at all). The tool can also be used with patients to facilitate shared decision making. Upon introduction of the tool in a pilot test, imaging utilization hit a plateau. HealthPartners estimates that within its own care delivery network, diagnostic imaging costs are now 10 percent below the state average in what has become a “lean cost” state for imaging.

More recently, HealthPartners’ health informatics department has developed Total Cost of Care and Total Resource Use measurement tools, which have been endorsed by the National Quality Forum (the tools are available free of charge at www.healthpartners.com/tcoc). Within the HealthPartners health plan, the measurement tools are used to shape benefit design (including reference pricing), offer price and resource utilization transparency to plan members, and work with network provider members (both within and outside of the HealthPartners care delivery system) to manage payment and incentive goals in shared savings programs with the health plan.

On the care delivery side, the tools are used to identify utilization and price patterns affecting the affordability of care that HealthPartners’ care delivery units provide. Park Nicollet, which has engaged significantly in risk-based contracting, has since its combination with HealthPartners established a total cost of care committee including vice presidents and chiefs of service lines (both HealthPartners and Park Nicollet use a “dyad” leadership model), HealthPartners COO Nance McClure, and HealthPartners vice president of health informatics Sue Knudson. The committee meets monthly to report progress and identify issues and manage a broad portfolio of projects. Park Nicollet has also hired a director of total cost of care who has been paired with a data analyst to work with service lines and move the needle on cost.

VERTICAL ACQUISITIONS, AFFILIATIONS, AND COMBINATIONS

Whereas horizontal combinations involve similar organizations within an industry, vertical combinations bring together organizations that supply different components of a service or product within an industry. In health care, a vertical combination might include a multispecialty clinic and a hospital, or a health system and a health plan.

Some combinations can comprise both horizontal and vertical components. An example is HealthPartners, which had both a health plan and care delivery components—i.e., hospitals and clinics—before its 2013 combination with Park Nicollet, which was composed of a multispecialty clinic and a hospital. For HealthPartners, the combination was essentially horizontal, expanding its existing care delivery network into the west-suburban portion of the Twin Cities metropolitan area. For Park Nicollet, the combination included significant “vertical” components, giving the organization access to HealthPartners’ health plan capabilities and data analytics.

Accountable care organizations (ACOs) are often vertically integrated structures, albeit less formal versions in many cases. One of the earliest and best-known is the affiliation between Blue Shield of California, Dignity Health, and Hill Physicians Medical Group to coordinate care for members of the California Public Employees’ Retirement System. It since has expanded to other markets and employers, with Blue Shield’s health plan, Dignity Health’s hospitals, and Hill’s physician practices sharing risk for managing to a budgeted cost of care for the population. The partners share claims data, pharmacy data, twice-daily hospital censuses, and information on admissions and discharges to enable predictive modeling and, in turn, proactive identification of candidates for case management, as well as active management of patients who are ill or in need of treatment.

Case study: Diversifying capabilities. The acquisition of Dean Health, based in central Wisconsin, by St. Louis-based SSM Health Care solidified a longstanding relationship between the organizations while enabling the vertical integration of Dean’s advantageous capabilities into the SSM system. Dean Health was a large, for-profit, multispecialty physician group with expertise in managing practices and running a health plan. Dean physicians had practiced at St. Mary’s Hospital, a facility in Madison, Wis., that is owned by SSM, and Dean and St. Mary’s shared an integrated EHR system and were participating in a Medicare ACO pilot. The level of familiarity between the organizations before the combination significantly eased issues related to integration.

The acquisition of Dean in September 2013 came as SSM’s revenues were shifting rapidly to non-hospital-driven sources. Within the newly merged organization,

which includes markets in Missouri, Illinois, and Oklahoma, as well as Wisconsin, the high degree of integration in Wisconsin has led to decreased costs and improved outcomes. While sensitive to the differences in its various markets, SSM is beginning to export aspects of the Dean model to other physician practices in building its consolidated medical group. SSM also immediately put health plan experts from Dean in charge of its self-funded employee plan and has realized immediate cost savings through steps such as switching to Navitus, a free-standing pharmacy benefit-management organization that was jointly owned by Dean and SSM and is now part of the SSM system.

The vertical combination of Dean Health and SSM “has given SSM the capabilities needed to transform to an integrated, value-based organization,” says Dayal, the president of healthcare delivery, finance, and integration for SSM Health Care. “The value of this acquisition will ultimately lie in our ability to continue to lower the total cost of care and improve clinical outcomes. We are very confident in accomplishing both of these objectives as an integrated organization.”

MULTISYSTEM COLLABORATIVE MODELS

These models, in which hospitals or health systems come together to work on operational or clinical initiatives while remaining independent, have emerged in several markets. Examples include the BJC Collaborative in Missouri and Illinois, the Granite Health Network in New Hampshire, Stratus Healthcare in central and south Georgia, Integrated Health Network of Wisconsin, and AllSpire Health Partners in New Jersey and Pennsylvania.

Many of these partners came together as recently as 12 to 18 months before this report was released. “Hospital board and executive teams are interested in participating in these arrangements because they offer the possibility of adding scale without ceding control over the organization,” says Kaufman Hall managing director Mark Grube.

Whether such collaboratives will have a meaningful impact on the market is unclear. “We will not know for several years whether these newer arrangements have achieved their goals,” says Quazi, managing director for BMO Capital Markets. Some goals will be harder to achieve than others, says Johnson, the former sector head and

managing director at BMO: “For example, decisions regarding rationalization of services and reductions in beds in markets with excess capacity are more difficult to make in a more loosely affiliated arrangement.”

Grube says many collaborative partnerships are focusing their attention initially on:

- Group purchasing activity
- Back-office functions
- Sharing of best practices, both operational and clinical
- Forming accountable care structures for risk sharing of managed-care activities

Not yet on the agenda for these partnerships are:

- Decisions on which services should be provided by which organization, an issue that could raise antitrust concerns regarding market allocation
- Control over clinical decision-making processes
- An integrated bottom line for the partnership

Case study: An innovation company. AllSpire Health Partners is a collaborative partnership of seven systems of similar size: Lancaster General Health, Lehigh Valley Health Network, Reading Health System, and Wellspan Health in eastern Pennsylvania; and Atlantic Health System, Hackensack University Health Network, and Meridian Health in New Jersey. The markets for the seven systems are geographically contiguous, but with relatively little competitive overlap. Combined, the member organizations represent approximately \$10.5 billion in revenue and a service area of more than 6 million people.

AllSpire does not have a dedicated infrastructure and staff; instead, staff from the member organizations contribute time to the governing board, councils, and committees that oversee development and management of the partnership and identify opportunities to pursue. Each membership organization contributes funding to support legal, branding, and outside consulting costs.

Governance and management of the partnership runs through three entities:

- The board of managers, which includes up to four members from each partner system, typically including the board chair and CEO. Leadership rotates among the partner systems alphabetically. Each member organization has one vote.

- The management council, which includes the seven CEOs of the member organizations. The council reviews initiatives proposed by the development committee and recommends approved initiatives to the board of managers for ratification.
- The development committee, which includes two C-suite-level executives from each member organization, representing legal, population health, finance, clinical, and operations to provide a balance of expertise.

The AllSpire partnership is intended to run as an innovation company. The development committee is the partnership's research and development arm, running ideas through a structured process of review and prioritization for consideration by the management council. The development committee meets for 90 minutes weekly, with additional meetings for co-leaders of committee subgroups. The subgroups are assigned selected initiatives, with a project manager assigned from a partner system and two subgroup leaders, one from a New Jersey system and one from a Pennsylvania system.

The development committee is taking a disciplined approach to identifying initiatives, recognizing the benefit of building momentum through early successes and of not taking on too much at once. Its efforts are focused on five initial areas:

- Population health, beginning with self-funded employee plans
- Laboratory and imaging services, focusing on opportunities for efficiencies of scale among the seven partner systems and implementation of recommendations from the "Choosing Wisely" campaign
- IT, with initial discussions focused on health information exchange, disaster data recovery, and common HIPAA strategies
- Group purchasing, especially novel relationships in which the partnership could share risk with vendors
- Clinical initiatives, focusing on those that create transformation in care delivery such as emergency department throughput and end-of-life and palliative-care strategies

After the management council and the board of managers approve an initiative, the partnership determines whether it needs to be structured as a separate joint-venture

organization and whether any additional partners should be added. Joint ventures are funded separately from the AllSpire partnership, based on analysis of capital funding needs and financial potential. Necessary funding is contributed by joint-venture partners, which may include all or some of the seven member organizations.

Case study: Bolstering care management. The Integrated Health Network (IHN) partnership in Wisconsin has taken a different approach than AllSpire, using a model in which member organizations fund full-time staff for the partnership. Among the primary goals is creation of a broad-based, clinically integrated regional network to provide a continuum of care management options, with single-signature authority to contract on a nonexclusive basis with employers and other payers. Accordingly, the member organizations have invested in a clinical IT infrastructure that includes a tool with risk-stratification and patient registry-creation capabilities. Among the staff funded by the IHN member organizations are care transitions personnel, who use the data and risk-stratification information from the IT infrastructure to identify the most critical patients and oversee their care.

IHN is a partnership of five health systems—Froedtert Health, Agnesian HealthCare, Ministry Health Care, Columbia St. Mary's, and Wheaton Franciscan Healthcare—and the Medical College of Wisconsin; Froedtert and the Medical College together form one of two academic medical centers in the state. The inclusion of the Medical College is considered an important asset in the partnership's effort to develop a clinically integrated network that can offer a full range of services to payers, employers, and patients.

Combined, the system comprises 34 hospitals, more than 450 clinic locations, 4,300 contracted providers, and more than \$7 billion in net revenue. The recent addition of Ministry Health Care has expanded the geographic territory well into northern and west-central Wisconsin, but most of the partners operate within the Milwaukee metropolitan area. Although the distance between many of the member organizations is not great, Milwaukee historically has been divided into small, contiguous markets with limited competition among them.

The three most important committees for IHN, each chaired by a CEO from one of the member organizations,

are market strategy and product development, finance, and clinical integration. With the partnership focused on creation of a clinically integrated network that can engage in risk-based contracting with commercial payers, the clinical integration committee has been the most active to date, engaged in developing common care protocols. Its initial focus has been on management of complex conditions such as diabetes, chronic obstructive pulmonary disease, asthma, coronary artery disease, hypertension, and heart failure. As IHN has begun to contract with payers, the finance committee has become actively engaged in reviewing terms.

IHN and United HealthCare entered into a shared-savings agreement that covered a population of about 53,000 as of January 2014. Within a year, the number is expected to increase to 100,000 and will include the self-funded populations of Froedtert Health, Medical College of Wisconsin, and Wheaton Franciscan employees. United initially is contracting with a subset of the IHN members, but the contract likely will expand to include the full network.

The ultimate goals of IHN are to:

- Develop differentiated core competencies in population health and risk management among the member organizations
- Develop new mechanisms for delivering services to populations
- Contract together efficiently under single-signature authority
- Develop long-term relationships with health plan partners to maximize the number of lives under management and reach a critical mass of risk-based revenue that will enable member organizations to focus more exclusively on managing healthcare expenditures

OTHER ACQUISITION AND AFFILIATION OPTIONS

As the HFMA member survey indicates, traditional hospital-to-hospital or system-to-system mergers remain most popular, but nearly half the respondents are pursuing an alternative form of acquisition and affiliation activity. Along with vertical integration and collaborative partnership models, these include joint ventures and operating agreements, management-service agreements, and numerous other options.

Hospitals and health systems also are looking at a wider field of potential partners. “We are seeing new types of companies emerge out of the more creative arrangements,” Quazi says. “There is more strategic diversity in the business models than ever before.”

Many organizations are pursuing different models for different markets, goals, or growth opportunities. Dignity Health, which operates hospital-based systems in markets in California, Nevada, and Arizona, recently acquired a 22-state chain of occupational medicine and urgent care centers and is considering investment opportunities in healthcare-related startup companies. “We don’t want to

LESSONS ON BUILDING A COLLABORATIVE PARTNERSHIP

Leaders from systems participating in the AllSpire Health Partners and Integrated Health Network (IHN) collaborative partnerships shared several lessons on collaboration.

Strive to obtain financial contributions from all collaborative partners. There will be expenses associated with legal, branding, and communication needs, and potentially IT infrastructure and staff funding. A financial contribution also demonstrates commitment to the partnership. Contributions may be split equally or variably among member organizations, perhaps depending on the size of the organization or its level of participation in partnership activities.

Stay disciplined in defining the partnership’s initial efforts. Try for some quick accomplishments to build momentum for the partnership, and don’t take on too much at once. Both AllSpire and IHN have worked to clearly define areas of focus.

Make sure key staff members from the participating organizations have the necessary time and energy to build the partnership. Even in a staffed model such as IHN, leaders from each organization will need to devote significant time to the partnership.

Define clear leadership roles on the various boards and committees to ensure accountability and develop a structured decision-making process. In particular, CEOs of the member organizations should take on active leadership roles to move decision making forward.

do everything ourselves; we like to partner,” says Dignity Health CFO Michael Blaszyk. “But you have to be capable of partnering well. So much of health care is about control, and some of that must be ceded in a partnership.”

One of the five items on Dignity Health’s transformation agenda is innovative and diversified business lines, and the system is pursuing a multipronged strategy to achieve this goal. “Our strategic question when contemplating a partnership is, ‘How do we build this into something that is economically fruitful?’” Blaszyk says.

Case study: Joint ventures. As described earlier, Dignity Health—through a joint venture with Blue Shield of California and Hill Physicians Medical Group—was among the first healthcare organizations to form a commercial ACO in an effort to contain costs of care for a defined patient population. Since then, Dignity Health has

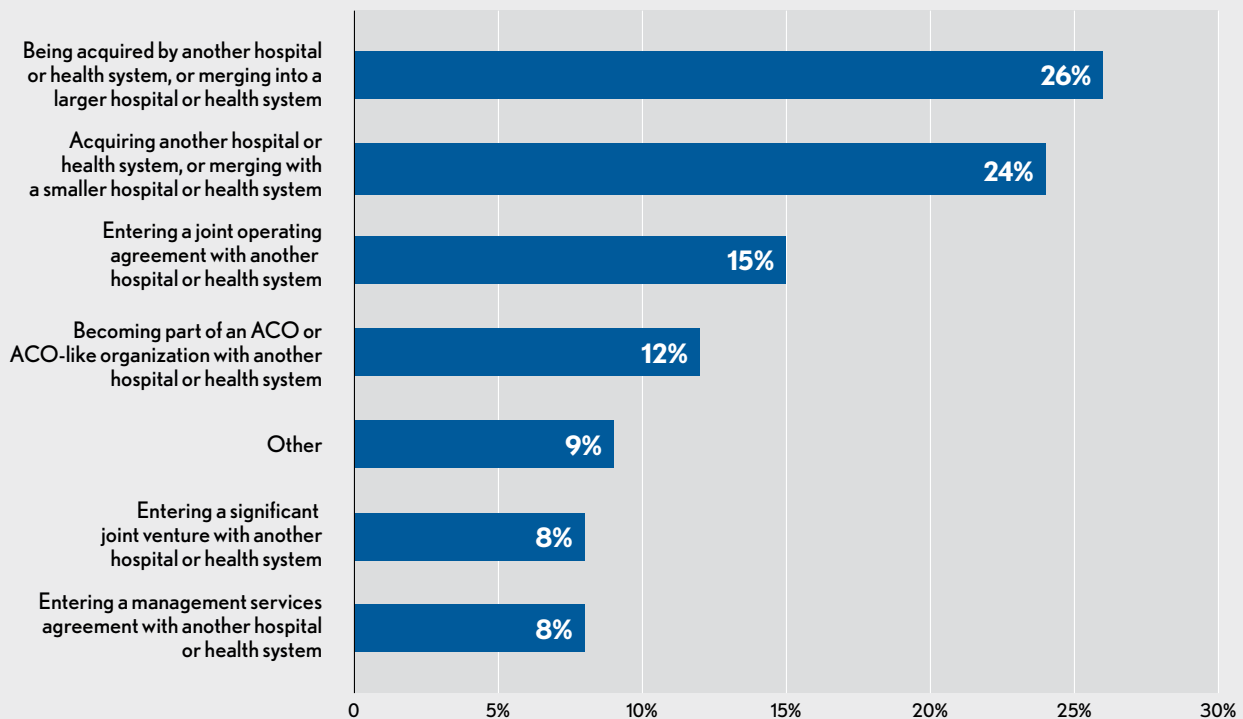
continued to pursue joint-venture opportunities with a range of “nontraditional” partners.

In one of its markets, Dignity Health and a for-profit system formed a joint venture that merged their local physician networks under a limited liability corporation co-owned by the two systems. The joint venture has created a marketwide network that allows both partners to compete more effectively against the biggest system in the market.

Dignity Health also has entered into joint ventures with United Health Group and its subsidiary, Optum. A venture called Shared Clarity combines Dignity Health’s clinical data with United’s claims data to assess the efficacy and cost of physician-preference items. Other systems can buy into the joint venture to expand the pool of clinical data and the volume of purchases that can be offered in negotiations with vendors that offer higher-value products.

PREFERRED ACQUISITION AND AFFILIATION ARRANGEMENTS

Which of the following options best describes the most significant type of arrangement your organization has pursued or is pursuing?



In another joint venture, Dignity Health and Optum teamed to create Optum 360, a national company designed to help healthcare organizations strengthen revenue-cycle processes. Dignity Health brings provider expertise regarding the revenue cycle, while Optum brings expertise in technological systems on the payer side.

Case study: Diversifying for national growth. In July 2012, Dignity Health announced its intention to acquire U.S. HealthWorks, the largest independent operator of occupational medicine and urgent care centers in the country. The acquisition gives Dignity Health a national footprint and provides a foundation on which to build additional population health capabilities. As a specialist in occupational medicine, U.S. HealthWorks has relationships with employers that could enhance Dignity Health's opportunities to directly contract with self-insured employers.

The acquisition is consistent with Dignity Health's interest in diversifying beyond acute care. Charlie Francis, chief strategy officer for Dignity Health, notes predictions that some strong regional systems are in position to grow into national systems. As opposed to a strategy of national growth based upon the acquisition of

acute-care providers that may need to be downsized as site-of-practice and utilization patterns change, the acquisition of U.S. HealthWorks provides a national platform on which services can be added while avoiding the higher cost structure of acute-care providers. "The acquisition of U.S. HealthWorks was a diversification opportunity that offers a higher profitability profile," says Lisa Zuckerman, vice president of treasury services for Dignity Health.

Case study: Investing in innovation. Dignity Health is taking advantage of its headquarters location in the San Francisco Bay Area to explore affiliations through equity investments with new healthcare-technology startup companies, another aspect of the system's focus on innovative and diversified business lines.

Investments in these companies serve several purposes. A health system offers sites for piloting new technologies with patients. Some of the technologies Dignity Health has invested in could significantly reduce the cost of certain services. Of course, if the technology is successful and finds a wide market, Dignity Health could realize a strong return on its equity investment.

LEGAL AND REGULATORY ISSUES

The primary legal and regulatory issues affecting acquisition and affiliation strategy concern antitrust law. The position of the FTC and Department of Justice (DOJ)—the agencies that enforce federal antitrust law—is consistent with a value-focused acquisition and affiliation strategy.^b Acquisitions or affiliations intended to produce pro-competitive effects, including improvements in quality, cost efficiency, or access to care, are less likely to be challenged if these pro-competitive effects outweigh any potential anticompetitive effects (for example, a

COLLABORATION, CLINICAL DATA, AND HIPAA

In addition to antitrust issues, healthcare organizations should be aware of changes to the HIPAA, made in subtitle D of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The HITECH Act strengthened both civil and criminal enforcement of the HIPAA privacy and security rules. The revisions define four “penalty tiers” with increasing levels of culpability, establishing a minimum to maximum range of monetary penalties for each tier, with the maximum penalty for violations of identical provisions of HIPAA within each tier in a given calendar year set at \$1.5 million. The HITECH Act also struck a limitation on liability when an entity covered by HIPAA was able to establish that “it did not know, and by exercising reasonable diligence would not have known” of a HIPAA violation. A covered entity in such a situation now must be able to establish that it corrected the violation within 30 days of becoming aware of it to claim an affirmative defense.

Although these provisions are of concern to all healthcare organizations, they should be of particular concern to organizations in looser collaborative partnerships that are sharing clinical data among partners to improve patient care. Organizations should carefully review their HIPAA compliance programs to ensure that shared data are adequately “scrubbed” to conform to HIPAA privacy requirements and that strong measures are in place to ensure the security of shared data.

more dominant position in the market resulting from the acquisition or affiliation activity). Generally, the greater the potential antitrust concerns, the greater the pro-competitive efficiencies must be. “An organization can gain dominant market power simply by being really good,” says Doug Hastings, chair emeritus of Epstein Becker Green in Washington, D.C. “Antitrust concerns are raised when that position is gained instead through acquisitions.”

Although the FTC and DOJ have defined “safety zones” for many types of acquisition and affiliation activity in health care,^c antitrust analysis is highly fact-specific. However, certain considerations provide insight as to whether antitrust issues might arise for the various acquisition and affiliation options described in this report.

HORIZONTAL MERGERS, AFFILIATIONS, AND COMBINATIONS

An initial question for horizontal activities is whether a change of ownership or control will be involved. If so, the activity could constitute a merger that requires pre-merger notification to the enforcement agencies.

A merger involving change of ownership or control is less likely to attract substantive antitrust scrutiny if the hospital being acquired operates in a separate geography and market from the acquiring organization and its subsidiaries or other affiliates or if the merger will not significantly increase providers’ market share or the concentration of providers in a given market.

Antitrust issues with respect to other transactions are less clear-cut. These include debt transactions where, for example, one organization provides capital to another and takes a minority position on that organization’s board. Management-agreement models may also be in a gray zone, although concerns are fewer if the managed organization maintains its own fiduciary board, no sharing of competitive information takes place, and no pre-established “triggers” would move the entities closer together.

“Transactions that do not involve acquisition of assets, but rather involve forming a joint venture, creating a contractual arrangement, or making changes in management, typically do not constitute a merger, and are unlikely to trigger the need for a Hart-Scott-Rodino filing,” says Hastings. “Such arrangements are less likely to be challenged, even where there may be market share concerns, so long as there are indicia of financial and clinical integration.”

VERTICAL ACQUISITIONS, AFFILIATIONS, AND COMBINATIONS

A U.S. district court decision early in 2014 to order a breakup of the affiliation between St. Luke’s Health System and Saltzer Medical Group has drawn new attention to antitrust issues related to vertical integration.

The case included allegations involving both horizontal and vertical integration, but was decided on the horizontal integration issues “because horizontal acquisitions are easier to challenge than vertical acquisitions,” says Bob Leibenluft, a partner at Hogan Lovells in Washington, D.C. “But the vertical integration issues are why the case happened. Those were the basis of an initial, private antitrust lawsuit by one of St. Luke’s competitors, which the FTC decided to join.”

The horizontal integration issues in the case involved a classic market-concentration analysis. Combined, primary care physicians in the Saltzer Medical Group and physicians already affiliated with St. Luke’s would have had 80 percent of their market in Idaho, enabling the combined group, in the court’s opinion, “to negotiate higher reimbursement rates from health insurance plans that will be passed on to the consumer.”

The vertical integration issues—not part of the court’s decision—dealt with referrals. Specifically, “buying up” referrals through acquisition of physician practices can help solidify or maintain the system’s dominant position in the market.

Although the FTC has focused primarily on horizontal integration issues, vertical integration is emerging as a new issue in health system acquisitions of medical groups, often introduced in private lawsuits. A key consideration

is whether the vertical integration will reduce horizontal competition among medical groups in a market. This is highly fact-specific, but the chances of attracting FTC attention increase considerably if there is horizontal market overlap between acquired practices. A second consideration is whether there is an appearance that a dominant system is “buying up” physician practices in a market. This can trigger private antitrust lawsuits from competitors, as in the St. Luke’s case.

Leibenluft offers these guidelines when considering a vertical transaction:

- Look at the transaction from the perspective of your competitors. Might it be perceived as an effort to foreclose referrals?
- Make sure your internal team is clear about the goal of the transaction and focuses its communications accordingly. If the goal is to create an integrated network to improve quality and cost-efficiency, speculation about the transaction’s impact on market power could bring that goal into question.
- Seek the advice of antitrust counsel early in the process if, as a general rule, your system commands 40 percent or more of the market and is looking to acquire or affiliate with a significant percentage of physicians in a given specialty or a significant percentage of primary care physicians in the market.

The accountable care movement has increased vertical integration in different configurations among health plans, hospitals, and physician groups. The FTC and DOJ have defined “safety zones” for ACOs that involve physicians, hospitals, and outpatient facilities and were created pursuant to the Medicare Shared Savings Program.⁴ The analysis of

CONVERSATIONS WITH FTC STAFF

HFMA thanks Christopher Garmon, Christine White, and Stephanie Wilkinson, all members of the FTC’s staff, for discussing issues related to federal antitrust law with us. These discussions reflected their personal opinions. Nothing in this report should be construed as representing official agency policy or guidance.

other ACOs—including commercial ACOs formed between provider organizations and health plans—would be similar to the analysis for joint ventures in which clinically integrated organizations are formed, as discussed below.

JOINT VENTURES, COLLABORATIVE PARTNERSHIPS, AND OTHER ACTIVITIES

Joint ventures between hospitals to create clinically integrated organizations are increasingly common. “These ventures typically use one of two basic integration models,” says John Marren, a partner with Hogan Marren in Chicago. “In the ‘best care’ model, a tertiary hospital forms a joint venture with one or more community hospitals. The tertiary hospital is able to upgrade the level of services provided at the community hospital, enabling it to manage lower-acuity cases, while higher-acuity care shifts from the community hospital to the tertiary hospital. In the ‘clinical integration’ model, hospitals work with physician networks to improve the quality and cost-effectiveness of care across the network.”

Hospital partners in both models typically have joint ownership of the clinically integrated organization, but designate a physician-led board with key committees such as performance, initiatives, infrastructure, and payer relations. The joint-venture agreement among the hospital and physician partners specifies an overall plan to create efficiency and improve quality through integration of hospital and physician efforts.

Marren identifies several key considerations in assembling these organizations. Regarding data gathering, the organization needs to make sure there is one platform and one set of protocols from the various partners. “Data is the game-changer today,” Marren says. “Consistency of data gathering among the partners is critical to the joint venture’s success.”

There must be an economic benefit to participation—e.g., an opportunity to participate in shared savings—for physicians in a clinically integrated network. Money for physician payments within a hospital-owned clinically integrated organization should not end up back at the hospital, except for what is needed to fund the integrated organization’s infrastructure.

Antitrust enforcement policy for joint ventures involving a clinically integrated organization is fairly well-settled, Marren notes. Key questions include:

- Is the clinical integration program real? In other words, does the program contain authentic initiatives, actually undertaken and requiring the active involvement of all participants in the network (described in a 1996 statement by the FTC and DOJ as an active and ongoing program to evaluate and modify practice patterns by the venture’s providers)?
- Are the program’s initiatives designed to achieve likely improvements in healthcare quality and efficiency?
- Is joint contracting with a health plan reasonably necessary to achieve the efficiencies of the clinical integration program?

Organizations should note, however, that clinically integrated networks that meet these descriptions could still raise antitrust questions if they have a high market share and could exercise market power.

Collaborative partnerships among independent hospitals and systems typically pose fewer antitrust concerns than more tightly integrated models, especially if market overlap between member organizations is limited. If the collaborative partnership is developing a network product, much of the discussion regarding clinically integrated networks applies.

If the collaborative partnership is developing a network product, much of the discussion regarding clinically integrated networks applies. Additional considerations include:

- Will the member organizations remain open to contract independently beyond the product that the partnership is offering? The risk of anti-competitive harm is mitigated if the member organizations remain non-exclusive in fact, as is the risk of having a complaining party, such as a health plan, initiate a private antitrust lawsuit.
- Are the member organizations carefully tailoring the information they share to their needs in developing the network product? Some information sharing is permissible; the key is to tailor and stage the information sharing. For example, what information is needed to make an initial “go/no go” decision on development of the product? If it is a “go,” what level of information

sharing is necessary to progress to the next stage in developing the product? Organizations should avoid substantial information sharing until they are confident that the product they are developing will likely move forward and should remain mindful of the guidelines on information sharing set forth in the DOJ and FTC's 1996 *Statements of Antitrust Enforcement Policy in Health Care*.^c

- Is the partnership reaching out to the payer community to keep it apprised of the partnership's legitimate goals and progress? Again, communicating with payers about how the partnership will achieve quality goals and cost savings can help to diminish any concerns that the member organizations are engaging in anti-competitive behavior.

With respect to other activities by collaborative partnerships, member organizations should be careful to avoid market-allocation concerns if they take up the issue of service-line rationalization. If members appear

to be dividing the market for services among themselves, potentially allowing each to dominate the market in a certain group of services, they could attract serious antitrust scrutiny.

Although antitrust enforcement typically focuses on monopoly power (i.e., the ability of a seller to control the market), it also can address monopsony power (i.e., the ability of a buyer to drive sellers' price below a competitive level). For example, if a collaborative partnership is engaged in group-purchasing activities and member organizations constitute a dominant block of buyers in the market for a specialized healthcare service (e.g., temporary nursing staff), they could be accused of exerting monopsony power. Such actions by organizations are rare, however.

Partners should seek the advice of experienced counsel whenever they suspect antitrust concerns may apply. But the general rule is relatively simple: If the goal and effect of acquisition or affiliation activity truly are to create value for patients and other care purchasers, the activity is far less likely to run afoul of legal and regulatory concerns.

CONCLUSION

From the beginning, HFMA's Value Project has emphasized the need to focus on the care purchaser's perspective. Value is created when the purchaser experiences an improvement in the relationship between the quality and the cost of care. As healthcare organizations contemplate acquisition and affiliation strategies, they must keep the purchaser's perspective clearly in sight.

The examples of acquisition and affiliation activity highlighted in this report have the potential to significantly increase value:

- AllSpire Health Partners' emphases on operational efficiencies and the sharing of clinical best practices aim to both enhance quality and offer more cost-effective care delivery.
- Dignity Health's multipronged strategy is engaging a wide range of partners in reducing total cost of care, forming networks that can offer competitive products to health plans and their beneficiaries, and investing in technologies and facilities that could significantly alter care delivery with improved access at a lower cost.
- Froedtert Health and the Medical College of Wisconsin are working to move lower-acuity cases to lower-cost care settings, while collaborating with their Integrated Health

Network partners on development of a clinically integrated network that is capable of risk-based contracting.

- HealthPartners and Park Nicollet Health Services have combined to provide access to their care delivery services across the Twin Cities metropolitan area, while maintaining their focus on total-cost-of-care and resource-utilization metrics.
- SSM Health Care's acquisition of Dean Health brings Dean's sophisticated provider-integration and managed-care capabilities into its system, accelerating its transformation into an integrated, value-based healthcare system.

Few doubt that the forces transforming health care today will lead to further consolidation within the industry. The difference is significant, however, between consolidation that seeks only to increase market power and an acquisition and affiliation strategy that seeks partners who can help produce the cost-efficiencies, gains in clinical quality, and access that care purchasers both need and demand. By taking the latter approach, healthcare organizations will be best-positioned to compete in their markets and win market share by offering patients, employers, and other purchasers a superior value proposition.

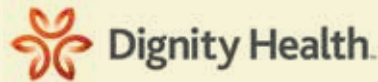
Footnotes

- ^a. Pitofsky, R., "Thoughts on 'Leveling the Playing Field' in Health Care Markets," The National Health Lawyers Association (now American Health Lawyers Association), 20th Annual Program on Antitrust in the Health Care Field, Washington, D.C., Feb. 13, 1997.
- ^b. States also enforce their own antitrust laws, typically but not always hewing closely to federal approaches.
- ^c. "Statements of Antitrust Enforcement Policy in Health Care," U.S. Department of Justice and Federal Trade Commission, August 1996 (ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care).
- ^d. "Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program," Federal Trade Commission and Antitrust Division of the Department of Justice, Oct. 20, 2011 (www.justice.gov/atr/public/health_care/aco.html).

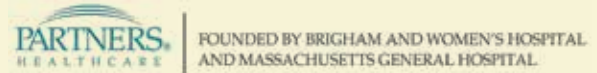
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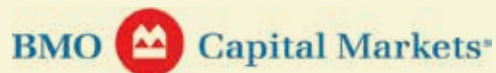
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**HFMA'S VALUE PROJECT: PHASE 3
ACQUISITION AND AFFILIATION STRATEGIES**

June 2014

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