The Healthcare Partnership Midrange

Health systems and hospitals are exploring business partnerships including joint ventures, ACOs, and integrated networks.

BY CHRISTOPHER CHENEY

The extremes of the healthcare partnership continuum are well-known and well-traveled: Narrowly focused clinical affiliations such as service contracts between hospitals and laboratories at one extreme, with mergers and acquisitions at the opposite extreme.

The middle ground of the healthcare partnership continuum is dotted with a variety of relationships that feature varying degrees of shared governance, including joint ventures, accountable care organizations, and integrated network pacts between health systems and hospitals that nearly match the intimacy of mergers and acquisitions.

Fountain Valley, California-based MemorialCare Health System, a system with 1,546 licensed beds across six hospitals and $1.9 billion in total revenue, is banking on joint ventures to help the organization maintain service revenue as medical procedures shift to outpatient settings, says Mark Schafer, MD, CEO of MemorialCare Medical Foundation, the system’s physician group division that has more than 2,000 employed and affiliated physicians.

Through a joint venture established in February 2013 between the foundation and Deerfield, Illinois–based Surgical Care Affiliates, MemorialCare is operating eight ambulatory surgery centers with plans to open as many as three more. The health system also is seeking joint venture partners to split
ownership of the organization’s 10 imaging centers, Schafer says.

MemorialCare holds 51% ownership of the ambulatory surgery center joint venture with SCA. The joint venture consists of the newly formed surgery center company, Beach Surgical Holdings LLC, which, in turn, owns 51% of the surgical center assets. The remaining 49% of the joint venture ambulatory surgical center ownership includes more than four dozen physicians. MemorialCare also wants to hold 51% ownership of the imaging centers, Schafer says.

“These types of services are moving out of the hospitals. The vast majority of these things can be done in freestanding facilities. We estimated 80% of ambulatory surgeries could be performed outside the hospital setting,” he says, adding that MemorialCare is garnering a patient experience boost through providing more services closer to patients’ homes at relatively low prices.

Any financial fears over a massive diversion of patient volume away from MemorialCare’s hospitals appear to be unwarranted, Schafer says, noting the joint venture ambulatory surgical centers’ physicians send patients to the MemorialCare facilities, including hospitals. “Initially, we thought these kinds of moves might have a negative impact on the health system, but the opposite has been true. Surgery and imaging is going to move out of the hospitals whether we want it to or not. We felt that, long-term, operating joint ventures was the right thing to do. It allows us to participate in some of the revenue stream.”

“This is consistent with the national trend of doing less inpatient cases and our ability to do more and more on an outpatient basis,” he says.

MemorialCare’s joint venture philosophy features shared governance and experienced clinical partners, Schafer says. “We have a seat on the surgery center board. We work together on growth. We work together on strategy. It’s much deeper than just contracting with an outside company. ... It really takes a strong partner to make these affiliations work. As we look to other lines of service or opportunities, we have to make sure we find a partner with the experience and willingness to work with us.”

**Accountable care organizations**

Partnerships developed through accountable care organizations are among the most recent innovations in the middle ground of the healthcare partnership continuum.

Radnor, Pennsylvania–based Delaware Valley ACO has participated in the Medicare Shared Savings Program since 2014, with four founding equity owners: Huntingdon Valley– based Holy Redeemer Health System, Philadelphia-based Jefferson University and Hospitals, Philadelphia-based Magee Rehabilitation Hospital, and Bryn Mawr-based Main Line Health. Doylestown Health, a small but highly integrated Pennsylvania health system centered on 237-bed Doylestown Hospital, joined the ACO in 2015.

Katherine Schneider, MD, president and CEO of Delaware Valley ACO, says the organization’s equity owners “are not cookie-cutter health systems—they’re all bringing different strengths to the table.”

Starting in January 2014, with 33,310 Medicare beneficiaries, the ACO’s 2014 MSSP spending benchmark was $394.8 million, and total spending reached $381.4 million. For the $13.4 million in shared savings that Delaware Valley generated in 2014, the ACO earned $6.6 million in shared savings payments, and Medicare saved $6.8 million, according to data collected at the Centers for Medicare & Medicaid Services.

Delaware Valley ACO is focusing its MSSP participation on primary care practices, with more than 430 participating physicians now serving about 65,000 Medicare beneficiaries. When the ACO divvies up the shared savings, there is a 30-30-40 split: 30% is allocated to the ACO for reinvestment and infrastructure financing, 30% is returned to the equity owners, and 40% is allocated to primary care practices.

As a business, Delaware Valley ACO is in its infancy, Schneider says, noting the equity owners are investing much more money in the ACO than the $6.6 million generated in 2014 shared savings payments. “The ACO’s share of that distribution doesn’t come near covering our current operating costs.”

Delaware Valley ACO is experiencing explosive growth, which is a positive sign for recruitment of participating primary care physicians but poses a challenge to attaining financial sustainability, she says. “We’re almost like a new ACO because half of the providers in 2015 are new. This is a journey we’re on together. We want there to be interest. We want more physicians to come in, but it makes it harder to predict as a business model.”

The ACO’s equity owners and primary care physicians are committed to
enduring short-term hardships to prepare for long-term success, Schneider says, noting Delaware Valley ACO is anticipating strong beneficiary and participating physician growth again this year. “The growth is because the horse has not only left the barn, it’s left the state, with CMS expanding value-based payments. We’ve tried to message to our physicians that this is coming.”

Delaware Valley ACO’s 15-member governing body (with 13 voting seats) has representatives from the five equity owners and a half-dozen other members, including community stakeholders and ACO physician-practice representatives. Among the equity owners, Jefferson Health has four voting seats, Main Line Health has four, and Doylestown and Holy Redeemer each have one. The CEO of Magee Rehab, which has a 2% stake in Delaware Valley ACO, has a nonvoting seat on the governing body.

Four primary committees report up to the ACO’s governing body: audit and finance, care coordination, information technology, and network development. The audit and finance committee includes CFOs from each equity owner. “Delaware Valley ACO is a separate company with representatives from its owner-members and community,” says Michael Buongiorno, CPA, executive vice president and CFO at Main Line Health. He serves as chairman of Delaware Valley ACO’s Audit and Finance Committee.

While Delaware Valley ACO has enjoyed a measure of early MSSP success, the organization faces challenges. Buongiorno says Delaware Valley ACO is facing a significant challenge—a rapidly expanding new organization with an untested business model. “How much do you invest to achieve the return on investment? It’s really about how much do you embed in your operations to create savings while improving the healthcare of the community.”

Linking specific physicians with measurable cost savings is a daunting actuarial hurdle, Schneider says. “As you mature as an ACO, you start to work in more performance-based initiatives. That sounds easy; but in some cases, actuarially, it’s just not possible. We’re not alone. … Everybody is looking at rewarding quality and rewarding population health. … If you try to pick it apart, it is more theory than mathematically valid,” she says, noting that it is actuarially impossible to assign every cent of shared savings to a specific physician.

ACOs must develop robust data analytics capabilities to determine where cost savings are being generated before doling out physician rewards based on performance, Buongiorno says. “That is the challenge—where are the savings really coming from?”

IT investment is critical to ACO success, Schneider says. “The big one is the population health platform,” which includes an integrated electronic medical record for equity owners and physician practices, data exchange capability, workflow tools tied to care coordination, and clinical systems upgrades.

Building a healthcare provider organization from scratch is a daunting task, Buongiorno says. “While this may provide a challenging endeavor, opportunities to invest in information technology and data analytics have the potential for us to improve care coordination, lower our costs, and improve the health status of the communities we serve.”

Delaware Valley ACO’s ownership members are taking a long-term approach to return on their investment, Schneider says. “This is like shifting the course of a battleship. … It’s changing the care model.”

Sole-member substitution affiliation deals

Dartmouth-Hitchcock Health, a Lebanon, New Hampshire–based health system featuring a 396-licensed-bed academic medical center, has established affiliation agreements with three relatively small hospitals in the organization’s service area: 169-licensed-bed Cheshire Medical Center/Dartmouth-Hitchcock Keene in Keene, New Hampshire; 35-bed Mt. Ascutney Hospital and Health Center, a critical access hospital in Windsor, Vermont; and 25-bed New London (New Hampshire) Hospital, a critical access hospital.

“It’s more than a clinical affiliation. It’s really a parent-subsidiary model with the goal of improving the coordination of care for the patients we serve and enhancing value by reducing cost and improving quality. The Dartmouth-Hitchcock system has certain reserve
powers over New London and the other two hospital partners that are pretty substantial,” says Stephen J. LeBlanc, executive vice president for strategy and network relationships at D-H. “It’s not quite a merger. They have their own boards. They have their own medical staffs.”

The legal framework for D-H’s hospital-affiliate trio is sole-member substitution, he says. “The governance model is the same for all three; however, I would not describe the model as shared governance in the manner that the phrase is commonly used. Essentially, under our affiliation agreements, the organization maintains its corporate structure, but Dartmouth-Hitchcock retains specified reserve powers, such as approval of key strategic and financial decisions as well as approval of affiliate board members and CEO selection.”

“In return for governance concessions, New London Hospital has gained preferential access to D-H tertiary care and specialists as well as D-H–driven patient volume gains in primary care, urgent care, and expanded levels of specialty care. “We’ve added several clinical services,” King says, noting D-H physicians in 10 specialty areas are treating patients in New London, including dermatology, oncology, orthopedics, and urology. “It means a doctor comes here to see patients as opposed to the community driving up the highway” about 25 miles to the medical center. The affiliation has improved bed census management for both D-H and New London Hospital. “We are often at full capacity and have to divert patients to other tertiary centers in the region. Part of the reason we are full is we are treating some low-acuity patients, too,” LeBlanc says, adding that D-H hospital affiliates are helping to ensure all patients in the D-H service area have access to the right level of care at the most cost-effective setting. “We have daily care management calls every morning. We understand whether New London will be able to take our transfers or not.”

New London Hospital’s daily bed census has improved dramatically since the D-H affiliation, rising from fewer than 10 patients to close to 20 patients, LeBlanc says. King notes that the D-H patient population is spread across 20 local markets and the health system functions more efficiently when low-acuity cases are treated at local facilities. “They don’t want to be jammed up with services that can be provided at the local level. ... They’re at capacity, and we have beds available. It’s very complementary and symbiotic.”

As market pressures increase on healthcare providers to consolidate and integrate, there are several options to lean on partners to ease burdens and seize opportunities. H

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