AMC Market Repositioning

Case Study: UI Healthcare

Presented By:

Jean Robillard, MD, Vice President for Medical Affairs, UI Healthcare

David Vellinga, President & CEO, Mercy Medical Center – Des Moines

Howard Peterson, Managing Partner, TRG Healthcare

Discussion Overview

I. Introduction *(Jean Robillard)*

II. Challenges, observations, predictions and emerging models related to AMC market repositioning *(Howard Peterson)*

III. Case Study: Creating the "University of Iowa Health Alliance" *(Robillard, Vellinga)*

   I. Motivation and Goals

   II. Structure

   III. Accomplishments/Challenges

IV. Questions

Today's Presenters

Jean Robillard, MD, Vice President for Medical Affairs, UI Health Care
Jean E. Robillard is charged with integrating planning and operations for the University of Iowa Hospitals and Clinics; the Carver College of Medicine; and the University of Iowa Physicians, the state's largest multi-specialty physician group practice. UIHC is one of the founding members of the University of Iowa Health Alliance.

David H. Vellinga, CEO of Mercy Health Network, President & CEO, Trinity Health-Iowa, and Senior Vice President – CHI Iowa
Mercy Health Network is a joint operating venture between Catholic Health Initiatives, headquartered in Englewood, CO, and Trinity Health, headquartered in Livonia, MI. Currently, MHN consists of 11 owned hospitals, one joint venture specialty hospital affiliate, 30 affiliated community hospitals, 142 clinics with 700 physicians and more than 13,000 employees working throughout Iowa and in portions of Illinois, Nebraska and South Dakota. Mercy Health Network is one of the founding members of the University of Iowa Health Alliance. Dave serves as the Chairman of this Alliance.

Howard J. Peterson, MHA, Managing Partner, TRG Healthcare. Mr. Peterson is the Founder and Managing Partner of TRG Healthcare. He has more than 30 years of healthcare experience as a chief executive and consultant. Mr. Peterson's consulting practice focuses on strategy, strategic transactions, academic medicine and healthcare innovation.

Key AMC Challenges Related to Market Repositioning

Everybody Knows…	Implication for AMCs
Rapid Provider Consolidation	• Non-AMC providers are gaining the size and strength to drive market dynamics and negotiate on an equal or better footing than AMCs.
Shift Toward Population Health	• AMCs which are not well positioned to be principal contracting entity for population risk contracts are likely to become "commodity" providers to others who are.
Reductions in Provider Payments	• Payments of all types are expected to decline including federal reimbursement (e.g. Medicare, DSH payments) and commercial rates; AMC cost structures (10-20% higher than competitors) are not sustainable.
Value-Based Payment Structures	• Payers and purchasers of care are less willing to pay a premium for patients to receive care at AMCs; AMCs must effectively compete on a cost basis for the majority of care that others also provide at acceptable levels.
Threats to Clinical Medical Education Funding	• There is no comprehensive policy for financing clinical medical education. The academic portion of the AMC cost structure and historical clinical education funding sources face significant downward pressure.
Multiple Missions of the Academic Organization	• AMCs need to find ways to reconcile mission commitments with changing economic realities and compete with community providers with only clinical missions, clearer hierarchical structures and often quicker decision-making.

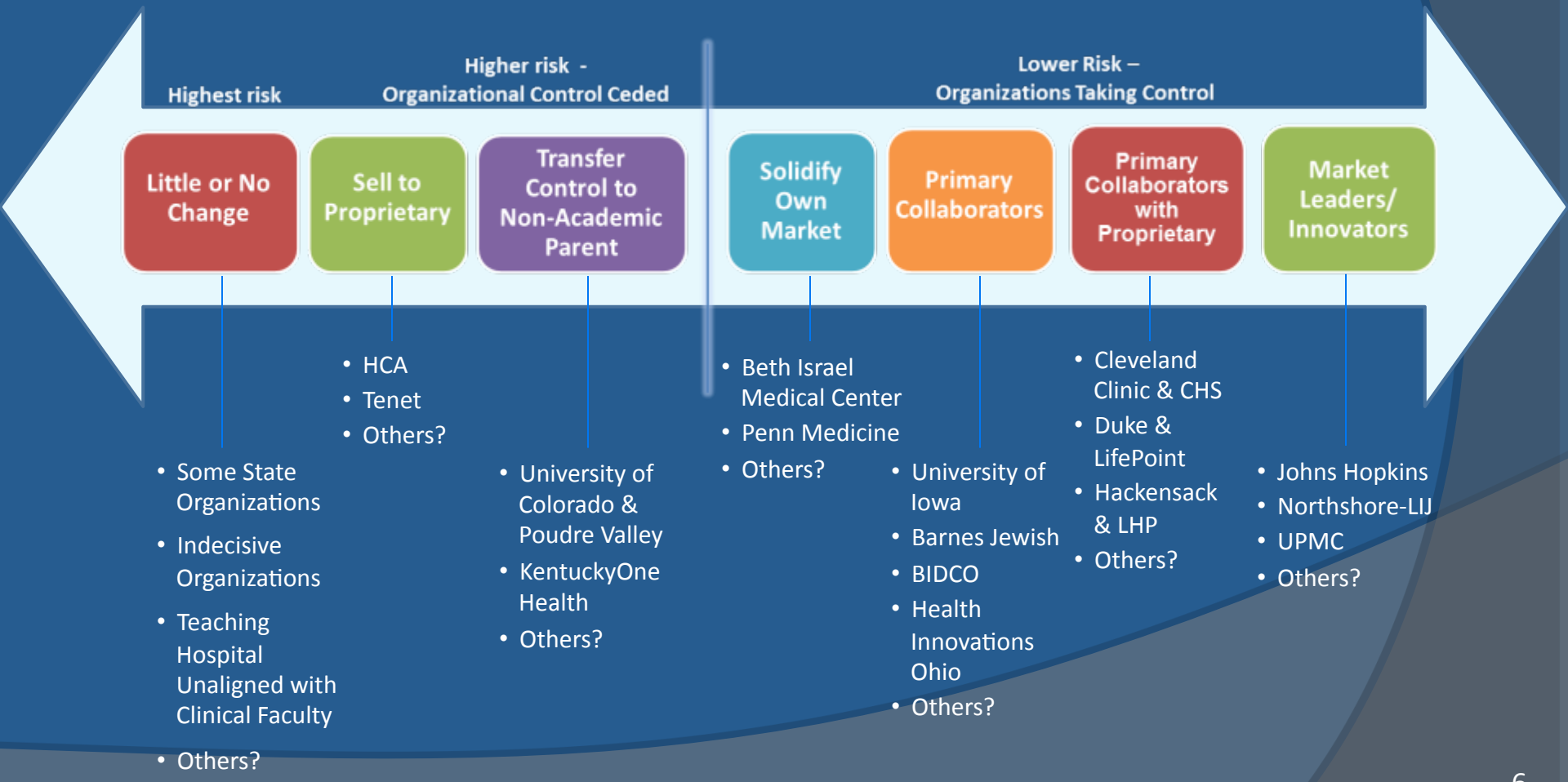
Other Less Recognized Challenges for Consideration

Other Challenges…	Implication for AMCs
Long-Standing Tradition of Concentrated Clinical Education	• Concentrating clinical education within limited inpatient and outpatient sites will be called into question by forces driving down inpatient utilization and shifting care to distributed outpatient settings.
Changing Economic Incentives Impacting Referral Decisions	• As providers assume risk for the cost of care, their referral decisions will no longer be purely clinical, detached from economic factors.
Outdated Academic Affiliation Agreements	• Many Academic Affiliation Agreements between clinical faculty and their primary teaching hospitals are outdated. These long term agreements did not anticipate the principles of population health or risk.
Emerging Clinical Science Limited by Cost Pressures	• With downward pressure on costs, it will be more difficult to introduce emerging science and technology without a strong economic value proposition.
Investments at Odds With Utilization Trends	• AMCs' substantial investments in single site inpatient and outpatient complexes are at odds with the negative trend line in inpatient utilization and access expectations.

AMCs will need to utilize Alternative Alignment Models to address these challenges and strategically reposition the organization

Observations Related to AMC Repositioning

AMCs are highly **stratified in the way they have chosen or been able to respond to the changes underway** in healthcare. AMC responses have developed based on different market conditions and organizational circumstances. As a result of their efforts or lack of efforts, they will face greater or lesser future risk (i.e., the probability of not being able to carry out & balance the three missions of the AMC).



Other Fundamental Observations for Consideration

There are a growing number of markets where AMCs have lost their dominant market position to large evolving systems.

Much of the consolidation that is taking place involves **alternative alignment structures short of merger** that allow partners to solve significant portions of their market and performance issues and can be implemented expeditiously.

AMCs are entering into non-traditional relationships with proprietary companies that would not have been contemplated in prior years.

Because of insufficient academic affiliation agreements or no agreements at all, AMCs are beginning to **reconfigure and reinvent their relationships with clinical faculty and medical schools**.

AMCs have become **more concerned with having sufficient primary care physicians** aligned with them to drive business and function under population health.

Predictions Related to AMC Repositioning

- Declining inpatient use, the movement of services to dispersed outpatient facilities, and the need to deliver care in the most appropriate, cost effective settings will drive **AMCs to contemplate more distributed clinical education** structures.

- The **judgments of referring physicians will change under the economic incentives of population health;** economic factors will be balanced against clinical considerations.

- The predominate **payment structures in the future will become the defining mechanism for how providers work together and evolve the collective clinical enterprise.**

- There will be **conflict between translational medicine and growing cost pressures**; introducing emerging science and technology will require a greater value justification.

- To be economically successful, AMCs will **have to exercise influence over a broader total market to drive enough volume** to support investments in facilities and technology.

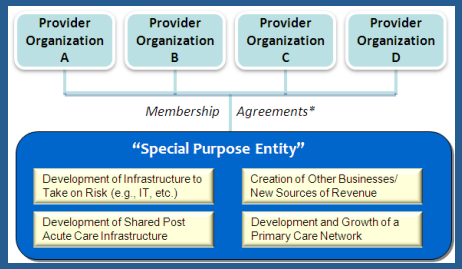
- More **AMCs will recognize that their existing Academic Affiliation Agreements did not contemplate health reform** and there will be broad restructuring of those relationships.

- Evolving **physician alignment models will include both clinical faculty and community physicians** because both are required to operate successfully under population health.

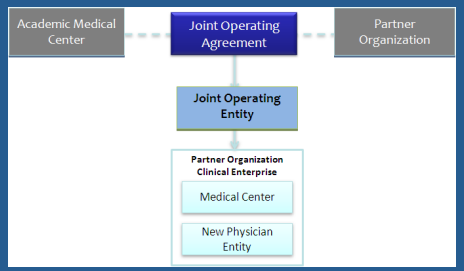
- **Faculty physician relationships with major teaching hospitals will evolve** to have more characteristics of partnerships than employment and control models.

Emerging Alignment Models

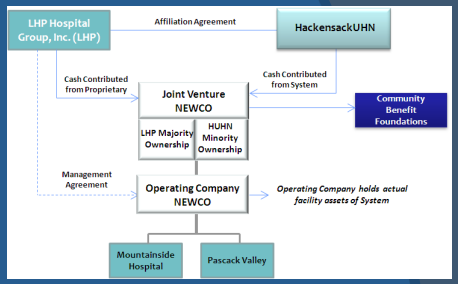
Special Purpose Entity



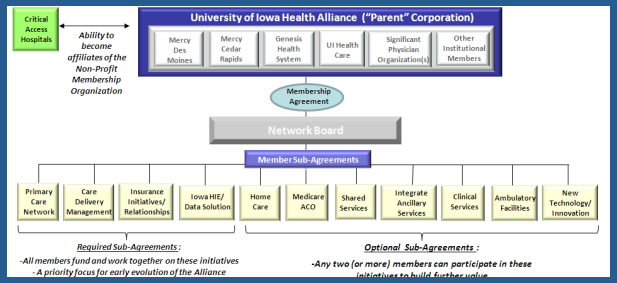
Joint Operating Agreement



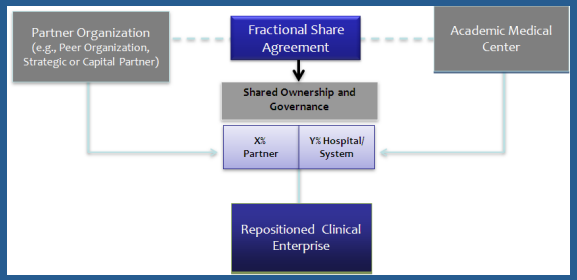
Consolidation of Hospital w/ Proprietary



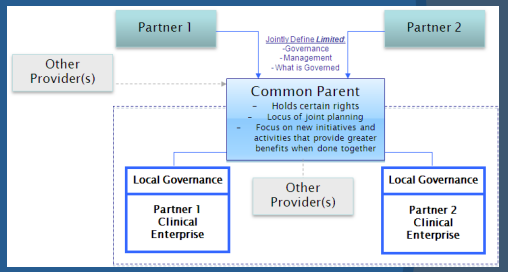
Integration without Merger



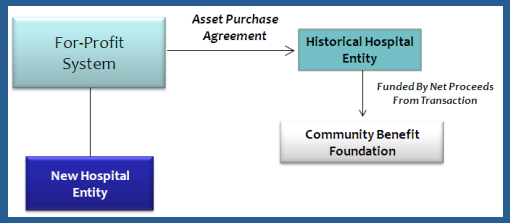
Fractional Ownership Model



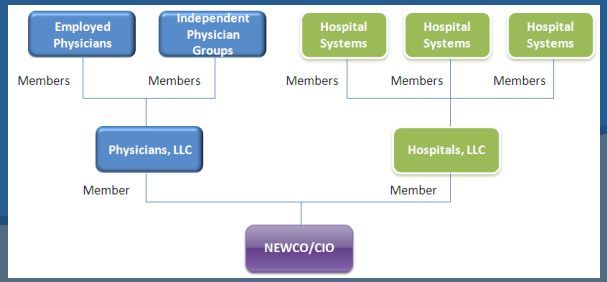
Creation of Common Parent



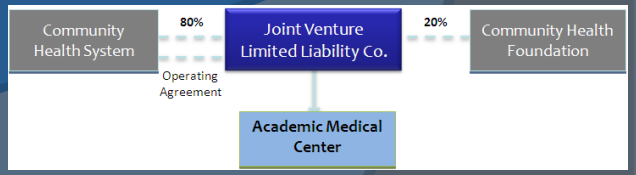
Full Acquisition by Proprietary



Inclusive Accountable Care Organization



Consolidation of Hospitals w' Proprietary: JV

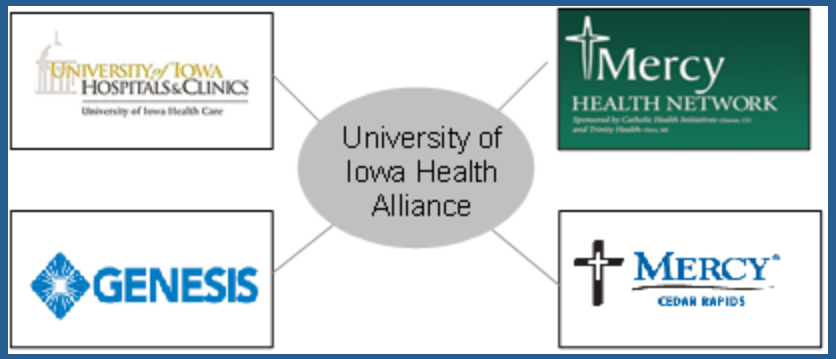


Case Study:

Creating the "University of Iowa Health Alliance"

Integration w/o Merger© in Iowa

- *Integration without Merger©* was successfully applied to support collaboration between four Iowa health systems, their hospitals and clinics.



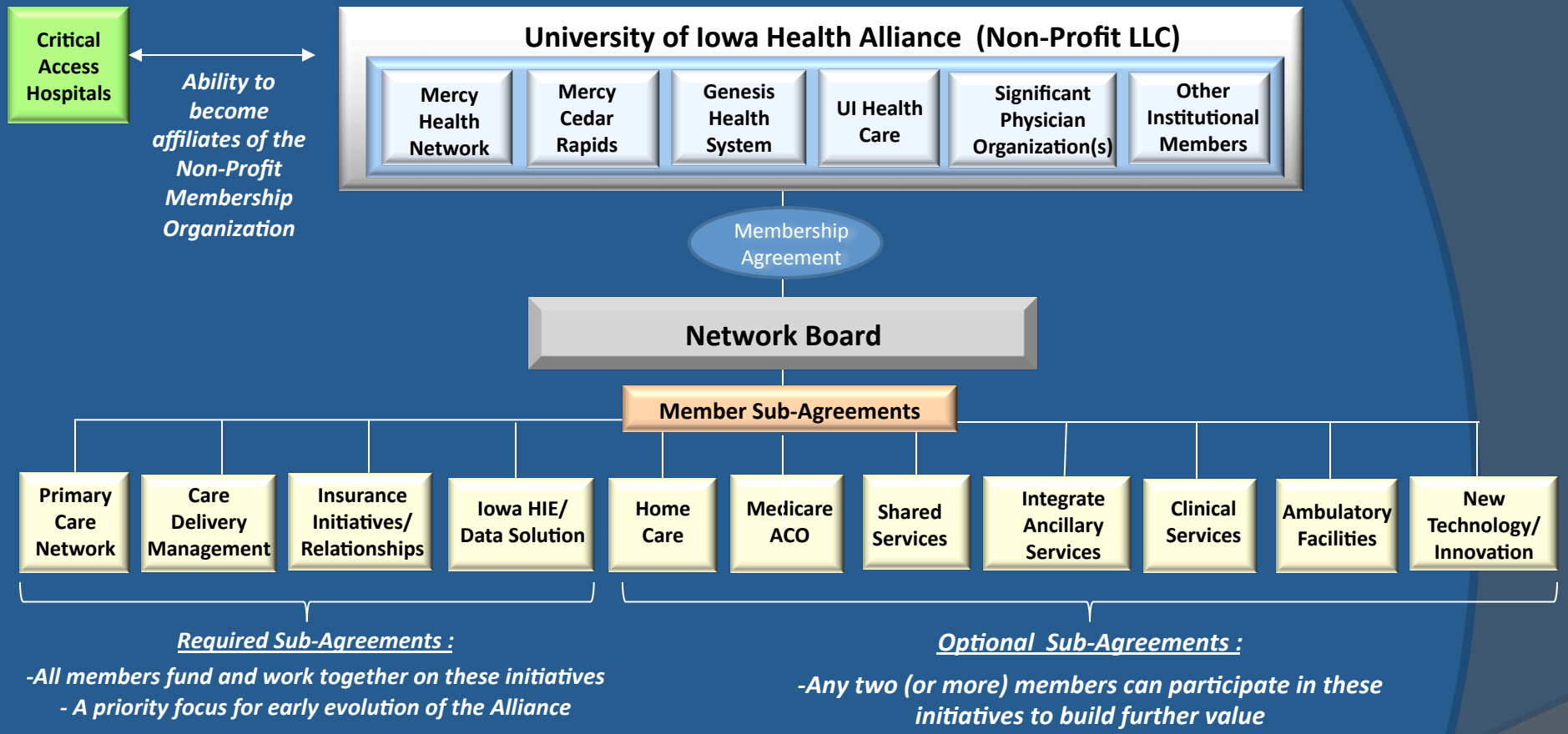
- The Alliance was formed in response to the rapidly changing marketplace and a common sense of urgency to work together to improve positioning.
- *Integration without Merger©* allowed these organizations to create a formal structure to achieve many benefits typical of merger while preserving the separate governance and mission of each organization.
- Today, the "University of Iowa Health Alliance" (UIHA) has been in operation more than one year and includes more than 50 hospitals and affiliated medical staffs and more than 160 clinics.

Network Motivation and Goals

- It started with a vision for a regional network of high quality providers who would create a distributed ‘System of Care’.
- Members established certain goals for partnership including:

- Develop a network that is sufficiently strong to compete with others in Iowa.
- Increase physician alignment with PCPs and specialists.
- Preserve or enhance the mission of the member organizations.
- Organize to assume risk for population health & respond to payment changes
- Establish a distinctly recognized brand differentiated by superior service
- Grow the total market share & therefore total revenue for all members
- Create economies of scale to reduce members effective cost per discharge
- Create a value proposition that attracts others to join in the future.

UIHA Structural Overview



Required Sub-Agreements :

-All members fund and work together on these initiatives
- A priority focus for early evolution of the Alliance

Optional Sub-Agreements :

-Any two (or more) members can participate in these initiatives to build further value

Three community systems were working together on population health and a commonly funded HIE data solution.

University of Iowa Health Care was working separately on strategic positioning in its market and saw a need to align.

The four parties came together and negotiated a corporate Membership Agreement to form an alliance.

The Agreement defined how the parties would work together as a Network Board and established that members would enter into sub-agreements of two types: (1) Required and (2) Optional.

Members built within the Agreement the ability to grow by adding other members over time.

The Alliance also has the ability to establish affiliate relationships with Critical Access Hospitals as appropriate.

Key Challenges/Concerns

Challenges	Solutions
• AMCs can be complex, slow and sometimes bureaucratic	• Have leader within AMC with authority to drive commitment to change and collaboration
• Developing trust between parties as the foundation for the relationship	• Without right leadership hard to develop Alliance
• Having sufficient number of staff and infrastructure for implementation and ongoing support of initiatives	• Cooperatively fund infrastructure; leverage internal resources of all 4 organizations
• Engaging other members to join Network – building the "strength of the Network"	• Need to have structure principles that will allow Alliance to grow; Need to produce real results in order to have a value proposition for other organizations to want to join

Questions & Answers