E-Briefings

Volume 13, No. 1, January 2016

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Affiliations: Matching Objectives and Risks

By James E. Burgdorfer, Juniper Advisory

Affiliations are contractual arrangements between two or more hospital partners in which they agree to work together on projects. No ownership or control is exchanged in affiliations; however, the term is sometimes used euphemistically, or incorrectly, to describe business combinations. These sorts of agreements have existed for many decades as non-profit hospitals have pursued contractual approaches to improve qualitative, operational, or financial performance. Most often, they represent an effort to share ideas and resources with an objective of economic efficiency and improved health while remaining independent.

Non-profit hospitals are actively considering their strategic financial options due to the economic and medical care implications of the Affordable Care Act (ACA). This activity has not, at least to the present, resulted in a meaningful increase in the number of completed business combinations. It has, however, resulted in a sharp increase in the number of affiliations that are being entered into. Despite the scant empirical support and bubbly atmosphere behind many affiliations, independent hospitals are actively pursuing them in an effort to access the benefits of increased scale without ceding ownership.

Because few parallels to affiliations exist in the corporate world, far less critical thinking has been given to them. This article seeks to begin to clarify some of the issues surrounding these structures, including the types of affiliation arrangements, certain risks to be considered, and a suggested overall framework in which to consider affiliations.

Affiliation Objectives

Affiliations take many forms, including management agreements, purchasing cooperatives, clinical affiliations, shared services agreements, and accountable care organizations (ACOs). Based upon the objectives of the partners, there are several types.

Clinical affiliations involve working with one or more partners to provide particular clinical services (e.g., cancer care). These are often arrangements between community hospitals and larger medical centers within a particular region. The larger partner is selected for its abilities and reputation in the relevant service lines. In addition, there are many co-branding affiliations between independent hospitals and nationally prominent medical centers (e.g., Cleveland Clinic, Mayo Clinic, and MD Anderson).

Scale affiliations center on achieving economies in certain operating areas, notably purchasing, information technology, billing, legal, and marketing. Two types of scale affiliations are particularly active in today's market and deserve note:

- Information technology: There is a tremendous increase in affiliations focused on sharing IT platforms. Inevitably, these involve larger hospital systems that "rent" their platform and expertise to independent hospitals, often in exchange for a break in cost. Theoretically, these arrangements are a mutually beneficial exchange of cash for services. In practice, however, they expose the smaller system to a number of unintended

risk factors due to asymmetries in the relationship.
- Population health: As hospitals seek risk-based incentive contracts to care for specific groups, larger population bases and a broad array of services are required. Independent hospitals are entering into ACO affiliations because they often do not have the number of patients to manage actuarial risk.

Contracting affiliations occur when hospitals seek to combine sufficiently to achieve coordinated payer contracting. These are subject to complex rules and usually involve long-term management agreements and other linkages. Blue Cross Blue Shield's refusal in late 2014 to negotiate rates with a clinical affiliation between Silver Cross Hospital, an independent hospital in suburban Chicago, and Advocate Health Care, the largest multi-hospital system in Chicago, reflects the difficulty present in these sorts of arrangements.

Perspectives on Risk

By their nature, affiliations are not well-suited for long-term needs. Rather, in varying degrees, they trade economic benefit for maintenance of ownership and governance control. Affiliations are often designed to promote flexibility and autonomy rather than to maximize outcomes. Hospitals that pursue affiliations to solve long-term needs, such as improving cost structures, face the risk of overreliance on a partner whose interests may change. While affiliations do a good job of preserving local control and are relatively easy to implement, certain drawbacks should be considered.

Operating risk occurs when affiliations are short-lived or fail to meet objectives. They are inherent in many affiliations because the parties often have separate core objectives. Since there is no exchange of ownership, it is easier for the parties to argue about resources and approaches rather than collaborating to optimize care for the community. Smaller partners in affiliations typically risk becoming too reliant on these structures. Should either partner decide to exit, the smaller partner is left weakened.

Corporate control and value risk relates to the possibility that hospitals entering into affiliations might become fully absorbed into their partner with no economic consideration being received. This existential threat needs to be avoided at all cost. These unfortunate outcomes usually result from operationally extensive affiliations in which the larger party achieves fundamental control over the smaller party. Some industry experts refer to these as slow-motion giveaways or bear hugs. This phenomena is exacerbated by certain contractual provisions often found in affiliation agreements, most notably rights of first refusal.

Unwinding risk occurs when hospitals find that terminating existing affiliations is more costly than continuing the relationship on unfavorable terms. Affiliation agreements sometimes include buyout provisions that are too expensive for the smaller members to execute, or that leave the junior partner with untenable financial management or operating gaps. Smaller organizations often surrender to the poor financial circumstances of the affiliation, or submit to bear hugs, if they find the cost of exiting to be prohibitively high.

Suggestions

In light of the risks of affiliations, additional consideration should be given on how to best structure these arrangements. A good starting point centers on three concepts:
- **Developing a basis of comparison**: Hospitals often enter into affiliations without understanding their full range of strategic financial alternatives. Since these sorts of arrangements are often incremental in nature, they are pursued without exploring alternatives. Absent a simultaneous evaluation of all reasonable alternatives, it is not possible to know whether another model would have been a better overall business and community decision. Our experience suggests that the full range of strategic financial alternatives should be well understood as part of the evaluation of an affiliation. Such comparisons also may identify benefits from other arrangements that might be foregone in an affiliation. A comparison of strategic financial alternatives can also give organizations an understanding of their market value.
- **Matching objectives with structure**: Since successful affiliations tend to focus on narrow and clearly identified improvements, developing a thorough and consistent set of affiliation objectives may enable participants to avoid risk. Also, affiliations are typically best at filling specific, near-term needs. To meet persistent needs, hospitals should

explore alternative structures, or at least consider the impact of affiliations on longer-term alternatives. For example, should a hospital wish to consider a merger within the foreseeable future (e.g., five years) it might be unwise to enter into an affiliation for short-term gain at the cost of an expensive exit from the contract. This is because future merger partners are likely to be focused on one's market share rather than current profitability.

- **Early consideration of termination provisions**: Affiliations are designed to have finite lives. The challenge lies in knowing how to unwind them when they no longer meet the needs of both partners. To spur consideration of termination terms, each partner might detail ways that they would be best positioned after the affiliation ends. An all-too-common outcome is for the larger organization to absorb the smaller one at a lower economic and non-economic sum than the smaller hospital would have garnered prior to the affiliation. To avoid this fate, independent hospitals should explore the range of termination options before agreeing to the affiliation.

Conclusion

Affiliations offer an alternative to mergers that can fill organizational gaps and better position hospitals in the changing payment and operating environments. In the right setting, they can create meaningful short-term value. Many organizations have used these structures to fill gaps and improve services while maintaining ownership and local control. However, organizations often do not recognize the risks these structures pose. An open and rigorous assessment of the full range of options is crucial. To mitigate risks of entering into an ill-advised affiliation that can damage the organization over time, independent hospitals should simultaneously review all strategic financial alternatives, choose a structure (affiliation or other) that best achieves its objectives, and carefully anticipate how a future exit from the arrangement could be achieved.

The Governance institute thanks James E. Burgdorfer, Principal at Juniper Advisory, for contributing this article. He can be reached at jburgdorfer@juniperadvisory.com.

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