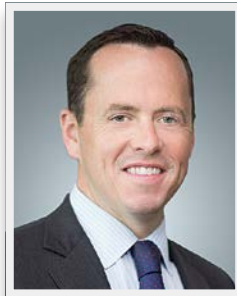


# Academic Medical Centers Active in M&A: Five Critical Success Factors

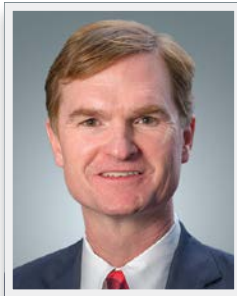
BY CHRISTOPHER T. COLLINS, ECG MANAGEMENT CONSULTANTS, AND EB LEMASTER, PONDER & CO.

AMCs have become increasingly active in pursuing new partnerships and consolidation strategies. While major teaching hospitals account for less than 7 percent of non-federal hospitals in the United States, AMCs have been involved in 20 percent or more of the announced change-of-control hospital transactions over the past three years—nearly three times the level in 2009.<sup>1</sup> The percentage involving AMCs climbs even higher if a wider range of structures is considered, such as clinical affiliations, collaborations, practice acquisitions, and clinically integrated networks. However, the paths taken by AMCs vary widely, such as:

- **New affiliations with major capital and structural commitments:** Includes new physician structures and 20-plus-year contractual mission support payments whereby AMCs have joined or aligned with regional health systems, such as the Banner Health–University of Arizona merger and the ProMedica–University of Toledo College of Medicine affiliation.
- **Statewide or regional collaborations:** Includes approaches without capital infusions or changes in ownership that provide important services and support, such as the Vanderbilt Health Affiliated Network and the BJC Collaborative.
- **Mergers and partnerships with community hospitals:** Such as Michigan Medicine–Metro Health and the University of Kansas Health System–Hays Medical Center.
- **Unwind and reemerge as an integrated academic health system:** Micro trend of AMCs exiting affiliations/alliances with national health systems to reclaim their major teaching hospital, and chart a new course. Examples include the University of Louisville’s plans to end its operating agreement with KentuckyOne Health, as



Christopher T. Collins  
Principal,  
ECG Management Consultants



Eb LeMaster  
Managing Director,  
Ponder & Co.

well as the University Hospitals Authority and Trust’s (University of Oklahoma) plans to end its 18-year operating and affiliation agreement with HCA.

Regardless of the path or approach taken, we offer five critical success factors below for AMCs to consider pre- and/or post-transaction as they develop new organizational and financial structures.

## 1. Leaner, Competency-Based Boards

Academic health systems and affiliated faculty group practices have historically embraced representative boards, which also tend to be larger than non-academic healthcare organizations (e.g., a faculty practice board with 25-plus members, including all department chairs). AMCs would be well served to get outside the political comfort of representative boards and adopt best practices from successful companies whose boards aim to establish an appropriate mix of perspectives and competencies while focusing on the best interest of the single entity. Further, the board should elevate itself to strategically and financially guide the organization—not manage its operations. With respect to size, 15 or fewer voting board members is a good starting point.

## 2. Integration between the Teaching Hospital and Physicians

Most consumers do not understand and/or frankly care about how hospitals and physicians are reimbursed differently by payers. They demand easier access to highly coordinated, specialized care at a lower

## Key Board Takeaways

Major transactions involving AMCs are at all-time highs and they run the gamut from light affiliations to full mergers. Boards should be aware that:

- Resulting organizational structures from these transactions are becoming more diverse.
- Regardless of organizational structure, there are a set of critical success factors required for academic health systems to thrive in the market.
- Ultimately, an AMC must balance its three-part mission while driving clinical margin to fund its future.

cost regardless of whether the costs are incurred by the hospital or physicians. That said, corporate structure notwithstanding, AMCs should aim to at least achieve financial integration between the teaching hospital and affiliated physician organizations to achieve benefits such as joint-payer contracting and shared-cost management of the non-physician expense structure (e.g., billing and collections, non-physician personnel, facilities). Studies have shown that the degree of functional integration between the teaching hospital and faculty practice can have a direct impact on the performance of the academic health system.<sup>2</sup> One highly effective vehicle for achieving financial integration is to pool all clinical revenue at the system level and, in turn, distribute funding to the hospitals and physician organizations/departments through a performance-based methodology that rewards productivity, access, quality and safety, and cost-efficiency.

## 3. Single Integrated Hybrid Physician Organization

Certainly the profile and orientation of a full-time clinical faculty physician can be very different from that of a non-academic health system-employed physician. However, the health system (which may include a major adult teaching hospital and several community hospitals) should expect and want physicians and staff to deliver consistently high-quality, patient-centered care regardless of site of service. That said, academic health systems that maintain multiple

<sup>1</sup> The percentage reflects total non-federal primary teaching hospitals (336) over the total number of non-federal U.S. hospitals (4,862), excluding non-federal psychiatric and long-term care hospitals (sources: American Hospital Association and Association of American Medical Colleges).

<sup>2</sup> Christopher Collins et al., *Are Integrated Academic Health Systems Better?*, ECG Management Consultants, November 2015.

physician organizational structures—including different governance, corporate, leadership, and financial structures—within the same system just to satisfy historical cultural differences (or avoid political resistance) will fall behind in the market. In a clinical capacity, all employed physicians within a system should aim to achieve maximum integration to the benefit of their single health system and the communities they serve. Further, the physicians should be treated equally with respect to clinical time and compensation based on performance and productivity.

#### **4. No (Health System) Margin, No Mission (Support)**

With the exception of a select few AMCs, external funding to support medical education and research has declined or remained flat on a per-faculty basis over the past five to seven years. This increases the dependency on clinical margin to supply the needed investments for growth and development in medical education and research. The health system's margin is ultimately the source of the investment as the physician enterprise margin continues to decline due to shrinking professional fee reimbursement. With universities and medical schools wanting and needing

more discretionary funding from the health system, AMCs should embrace more performance-based and formulaic approaches to “mission support” payments. For example, a meaningful variable payment to the university could be tiered and based on the overall financial standing of the health system. This positions the payment as an investment in the academic enterprise while aligning the financial interests of the parties (regardless of corporate structure).

#### **5. Shared Accountability with Strong Physician Leadership**

In a market that is demanding more price transparency, greater cost efficiency, and higher scores for quality and safety, an AMC will not thrive without the legitimate engagement of chairs and physician leaders. Historically, many large teaching hospitals have relied on an administrator-led structure with physician “input.” High-performing and highly ranked AMCs and large non-academic health systems have long embraced a physician-led philosophy commonly with a dyad structure that teams physician leaders with administrative executives at every level in the health system. Ideally, the chair of the academic department (or division chief or designated center director) in the medical school

concurrently serves as an empowered chief of service in the primary teaching hospital with shared accountability for operations spanning inpatient and outpatient services.

The organizational, cultural, operational, and financial challenges that present themselves during major transactions involving an AMC are fundamentally different and more complex than those between multiple non-academic parties. Further, AMCs have historically had a mixed reputation for their ability to be nimble and responsive to the fast-moving healthcare market. As the clinical enterprise of an AMC embarks on a new partnership or major restructuring, it presents a ripe opportunity to rethink and reset the governance, leadership, and financial structures. Building a more contemporary structure and streamlining the manner in which decisions are made and resources are allocated will help enhance the market position of the health system, improve its margin, and more effectively sustain the three-part mission of the AMC. ●

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