Trustee
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Partnering in the New Health Care Environment: 5 Questions for Boards

Health care is transforming to a value-based model, with the goals of improved care quality, access and outcomes for consumers, at lower costs. The means of achieving these goals is the effective management of health and health care services over the continuum of a population's care and service needs.

New competencies are required of hospitals and health systems to thrive in the new environment — clinical integration; consumer, clinical and business intelligence; operational efficiency; purchaser relationships; and optimized network development.

Hospitals and health systems are partnering to acquire or otherwise access the capabilities and efficiencies that let them provide services under new care delivery and payment arrangements. Partnership agreements include traditional structures, such as mergers and acquisitions, and collaborative arrangements, such as joint ventures, management services agreements and brand extensions.

Examples of such partnerships appear in *Guide to Health Care Partnerships for Population Health Management and Value-based Care* (Health Research & Educational Trust and Kaufman, Hall & Associates LLC, 2016, **www.hpoe.org/resources**). Complementing this guide, this workbook offers trustees and executive teams specifics around five questions that must be answered before partnering. These questions should be addressed during board and executive meetings to ensure that the leadership team identifies and secures arrangements that will best position the organization for success in the changing environment.

1. WHAT IS OUR ORGANIZATIONAL STRATEGY?

Disciplined strategic planning and execution starts with an engaged board of directors and key members of the senior executive team. They set the tone for the organization, establish expectations and engender broad participation. They also ensure that the organization commits to monitoring progress in execution and appropriately recalibrating its strategy as needed.

Planning must be informed by a clear point of view from leadership about the future of health care in the organization's region and account for the realities of industry changes and regional dynamics. It also requires consideration of market forces, such as consumer price sensitivity and competition from nontraditional entrants in retail and imaging services.

Planning need not be precise or rigid but instead should be directionally accurate. For example, if a health system's strategy is to extend its delivery system to a broader population in a defined region, partnerships likely will be a core element in that strategy. Scenario analyses of "build, buy or partner" options can estimate general upward or downward utilization

— TRUSTEE TALKING POINTS —

- With the move toward value-based health care, some hospitals need new capabilities.
- Partnerships provide an efficient way of adapting to the new environment.
- A number of questions should be answered before boards and management form partnerships.
- Boards need trustees with specific skill sets to keep their organization agile and allow it to adapt to new arrangements in a value-based world.

BY ANU R. SINGH WITH MARY K. TOTTEN

trends for specific network components, such as a post-acute care facility or ambulatory clinics.

An organization's role may be extended to the full or a defined portion of the provider care continuum, which includes virtual and ambulatory services, inpatient care and post-acute care, as well as health plan ownership or participation (as a partner). For example, the strategic choices defined by Seattle Children's Hospital include partnerships with health systems, primary care providers, payers and community organizations.

The current legislative and regulatory environments influence tactics, not strategy. Strategy is the overall objective; tactics are the means or "enablers" to achieve an objective.

2. WHAT IS OUR CURRENT SITUATION?

To answer this question, leaders should identify the organization's strengths as well as the capability gaps it needs to fill to meet its desired strategic role. Areas where expertise will be needed by organizations for effective population health management include:

- A network or participation in a network for the full continuum of services.
- Care coordination across the continuum, inclusive of health maintenance, chronic disease management, treatment of acute illnesses, and services in post-acute, ambulatory and home settings.
- Efficiency of the core organization and the extended delivery network, which involves use of evidence-based protocols, team-based delivery, care coordination and virtual platforms in an effort to simultaneously improve outcomes and manage costs.
- Clinical and business intelligence, required to set appropriate clinical goals and intervention targets and to effectively manage performance.
- A strong financial position, which enables organizations to make the investments needed to manage population health in their communities.

Boards that commit early to building or partnering to obtain the competencies, infrastructure, and intellectual and financial resources required to manage a population's health can guide their organizations toward a leading role in their communities.

3. WHAT DO WE WANT TO OFFER AND WHERE?

Effective management of a population's health entails the design and continuance of a high-performance network that covers the full care delivery continuum, or a portion thereof, under an aligned contracting strategy.

Typically, partnering considerations for providers center on their current and desired physician network, and the nonacute (e.g., clinics) and post-acute (e.g., nursing facilities) providers in targeted geographic areas. The sidebar on this page indicates specific criteria trustees must consider. These criteria are not mutually exclusive, and each has certain nuances that will be important for trustees and executive teams to understand and evaluate.

As leaders determine the right breadth for their network, trade-offs will become apparent. The broader the network, the harder it typically is to manage consistency of clinical practice throughout the system — especially without vested and aligned partner entities. The nar-

Business and Delivery System Considerations

- **Core businesses:** Leadership should evaluate each business or service against a number of criteria: Is this a core service required to deliver on our mission? Is this service fully integrated into the fabric of our organization and its care delivery model? Is the service well-positioned competitively? Will this service be relevant under ongoing reform and a new business model? Is our organization best-positioned to own or to effectively and efficiently partner or collaborate for this service?
- **Network essentiality:** To be considered essential, a network must provide the breadth and depth of care desired by the purchaser (e.g., a payer or employer) and be able to handle the projected volume of patients. Also known as reach, network essentiality is based on an organization's primary care network and/or geographic presence and is measured as a population that is served by the network.
- **Network adequacy:** Network adequacy, or depth, refers to the capacity of in-network primary care and specialty physicians, hospital services, and other specified continuum-of-care services. Depth depends on the needs of the population, so health systems should be thoughtful about whether they are able to build, contract for and deliver an appropriately deep network.
- **Service and distribution right-sizing and right-siting:** To succeed under value-based arrangements, many organizations likely need to systematically reconfigure their networks of facilities and practitioners to be highly efficient, deliver consistent quality across all sites, and manage patients in the least-intensive setting possible while still providing the necessary level of care. Unnecessary duplication of services must be eliminated, and nonperforming activities or services should be minimized. Proactive distribution moves often center on optimal physician locations and virtual services such as telehealth.
- **Network growth strategy:** As population health management–focused arrangements reshape utilization, many hospitals and health systems will need to invest in or partner with other entities. Growth typically requires geographic expansion through strategic partnerships, or affiliations with employers, providers and health plans.

Source: M.E. Grube et al., "Managing Population Health: A Strategic Playbook for Best-Fit Growth Opportunities," Kaufman, Hall & Associates LLC, 2015, www.kaufmanhall.com/software/white-paper-detail/managing-population-health

rower the network, the more difficult it will be to manage the provider risk associated with a more limited base of services.

4. WHAT LEVEL OF RISK WILL WE ASSUME?

Participation in managing a defined population's health under risk-based or value-based arrangements is *the* business imperative for hospitals and health systems. Governance and leadership teams will need to determine the level of provider risk their market is likely to require and the level of risk the organization will assume. Risk ranges from low-risk, pay-for-performance programs to case rates (e.g., episode-of-care or bundled payments) to partial or subcapitated risk to delegated and shared risk and up to full global capitation (see *Value-based Contracting*, Health Research & Educational Trust and Kaufman, Hall & Associates, 2013, **www.hpoe.org/resources**).

Success with risk-sharing partnerships typically depends on some level of economic integration or alignment around provider risk. In PHM contracting arrangements for hospitals and health systems, risk falls into two categories.

Provider risk is assumed by the entities delivering health care services and includes:

- Clinical or performance risk, which is the ability to deliver patient care that exceeds the targets for safety, quality, compliance and other measures defined in the risk contract with the payer.
- Utilization or financial risk, which is incurred by a provider organization through acceptance of a fixed payment in exchange for the provision of care anticipated to have an expected level of utilization and cost.

Insurance or plan risk is assumed by hospitals and health systems that have their own insurance plans, with responsibility for attracting and retaining members and the overall costs of plan administration and/or care delivery.

The key questions for trustees and executives are: What is the primary source of economic alignment — for example, a contract, joint venture arrangement or new-company agreement? What is the anticipated revenue model? How will success be measured and achieved?

Some hospitals and health systems are assuming direct insurance or plan risk. Provider-sponsored health plans are health insurance products or plans that are owned and controlled by one or more hospitals or health systems. The provider or providers manage not only the total cost of care but also the full financial risk for insuring the patient. In exchange, they receive and administer the full premium payments.

For example, Cone Health, a provider network with six affiliated hospitals in North Carolina, has a license to offer health insurance plans, including a Medicare Advantage plan. It also initiated a joint venture with a Texas-based independent practice association, which will provide the infrastructure to handle insurance claims and policies.

Boards considering taking on a health plan should answer the risk-related questions in the sidebar on this page. The risks can be significant for hospitals and health systems, but each opportunity is region- and organization-specific and requires thorough evaluation by governance and leadership teams.

Thinking About a Health Plan?

If you are a board member of a hospital or health system considering taking on a health plan, here's what you need to ask:

1. Does our organization need health plan capabilities and infrastructure to achieve its vision?
   - If yes, does it need to have full capabilities, or can selected plan capabilities be assumed by another entity?
   - If no, what's the desired relationship with the entity that brings the covered attributed lives to contracting arrangements?
2. Can our organization meet the clinical efficiency and efficacy requirements for assumption of risk to finance the new care-delivery model?
3. How will we assess and report data related to clinical care, and how will we engage physicians in performance improvement to achieve mutual benefits?

5. WHICH PARTNERSHIPS SHOULD WE PURSUE?

Transition to the value-based model is driving new partnership objectives to meet PHM goals. Historically, partnerships have been transactional in nature, involving organizations looking for a stronger partner to provide capital for continued provision of services in the community. Today's partnerships are transformative, powered by organizations of all sizes and types looking to gain or access core competencies related to managing risk and value arrangements.

Organizations are pursuing many different kinds of options, with traditional and creative partnerships and affiliations proliferating nationwide. Combinations of acute-care hospitals in the U.S. — through mergers, acquisitions and joint ventures, as well as affiliations in which a smaller not-for-profit hospital becomes a corporate member of a larger not-for-profit hospital's parent organization — have continued an upward climb. Beyond traditional M&A activity, nontraditional strategic partnerships include health systems partnering with payers or plans and clinician networks, and payers partnering with clinician networks.

Creative partnerships often are strategically structured to increase the expertise, resources or market position that has been identified as critical for an organization's future success:

AtlantiCare, Geisinger Provide Answers

In October 2015, Atlantic City, N.J.–based AtlantiCare health system officially joined Danville, Pa.–based Geisinger Health System, catalyzing the effective and rapid execution of a value-driven model in southern New Jersey. The merger followed AtlantiCare's successful building of a culture of quality and transition to a population health focus over nearly 20 years.

Some five years before the merger, AtlantiCare was aware that larger covered populations would be needed to ensure the highest-possible quality and to manage the financial risk of doing so. AtlantiCare's board and senior leadership group embarked on a facilitated best-practice strategic options evaluation process that included the following steps, answering the five questions raised in the main section of this workbook:

Step 1: Develop a "point of view" about the future. This point of view was based on a realistic assessment of trends in the region and informed by a national perspective on the new business model with its "do better with less" mandate. Despite historical success, AtlantiCare's leaders wanted to ensure that it could deliver on its community population health promise into the future. The key strategic question was the scalability of the model.

Step 2: Assess the organization's current position and future. The assessment, addressing questions two and three, included strategic, financial and credit positions, expected gaps, and risk. The board evaluated "big-picture" strategic alternatives, including remaining in the current configuration, proactively partnering with other providers, integrating into a much larger system, or pursuing nontraditional partnerships such as integration with a health plan.

Step 3: Develop the guiding principles. The effort to provide the foundation for any partnership exploration process, principles and the defining characteristics of an optimal partner covered culture, governance, employees, physician alignment, ability to deliver value-based accountable care and seven other topic areas.

Step 4: Evaluate and make a choice about the big-picture options and identify the best-fit partner. Proactive identification of the universe of partners to meet population health–focused growth objectives involved methodically identifying likely suspects as well as outside the box possibilities based on management, board and consultant experience and research. By applying the guiding principles, a wide field of 30 or 40 organizations was quickly narrowed to three, and Geisinger Health System emerged as the best-fit partner.

Source: Kaufman, Hall & Associates LLC and AtlantiCare, "Partnering for Population Health: The AtlantiCare/Geisinger Story," 2016, info.kaufmanhall.com/download-wp-atlanticare-geisinger-story

• **Granite Health**, a partnership of five of New Hampshire's largest health systems, and **Tufts Health Plan**, one of the leading health insurers in the country with more than 1 million members, in April 2015 announced a joint venture for a new insurance company named **Tufts Health Freedom Plan**. The goal is to provide residents of New Hampshire with coordinated, high-quality and cost-effective health care coverage through insurance products and provider networks that focus on PHM. A variety of health plans are available to employer groups. Operations launched in New Hampshire in January 2016.

• **Ascension Health Michigan, Trinity Health Michigan and physician partners** across Michigan created a physician-led network of health care providers named the **Together Health Network**. The network includes 25 hospitals, more than 100 ambulatory centers and physician offices, and the anticipated participation of more than 5,000 physicians. The network is designed to participate in value-based contracts to manage covered populations statewide.

• **Mayo Clinic Care Network** is an example of a brand and expertise-extension partnership. The Mayo Clinic's knowledge and expertise are provided to hospitals and health systems, which are invited to join the network following a comprehensive evaluation process. The network has 40 members comprising more than 100 hospitals. Among other offerings, members share clinical services such as eConsults and a point-of-care tool that gives members access to Mayo-vetted disease management protocols, care guidelines and treatment recommendations.

THE GOVERNANCE ROLE

The governing board's role is to ensure that the leadership team has articulated and is pursuing a "no regret" strategy for partnerships. Fiduciaries must appreciate and advocate that the drivers of past organizational success may not be the drivers of future success. Organizational agility is now required in health care. Such agility enables organizations to nimbly operate current business while simultaneously preparing for evolving, new conditions.

Skill sets among trustees will need to evolve to accelerate progress on the value agenda under partnership arrangements. A board composed of trustees who have specific competencies in and outside of health care will be helpful. Examples include:

• **Talent management** or experience working with and incentivizing highly educated or skilled individuals can be helpful in attracting and retaining clinical leaders to achieve a clinical integration agenda.

• **Growth strategy insights and negotiation skills** could be helpful in securing the best partnership arrangements and managing the organization's care delivery network.

• **Insurance, risk management and employer benefits management**

expertise (for example, that of a human resources director for a large employer) could help advance managed care relationship objectives and mitigate overall risk.

• **Business intelligence and customer relationship management** expertise in digitally enabled (i.e., internet, cloud and mobile) companies could enhance consumer engagement initiatives.

• **Change management** in companies that have successfully navigated a substantial transition could offer valuable lessons learned.

Beyond broadening of board competencies, trustees also should ensure depth of experience in PHM and network development on the executive team. Expertise in assessing and managing population health risk will mitigate the overall risk assumed by the organization under partnership and contractual arrangements. An executive with deep expertise in network development to support PHM, particularly with post-acute care providers, is a new role that also should be considered.

These are complex issues involving large potential partnership decisions. "Partnering for Population Health: The AtlantiCare/Geisinger Story" (Kaufman, Hall & Associates and AtlantiCare, 2016, **www.kaufmanhall.com**) describes how one health system's governance and leadership worked through the five questions in this workbook and determined their approach to partnership. Their process is summarized in the sidebar on the previous page.

The drumbeat for health care's transition from volume to value is growing considerably louder. Boards of nimble provider organizations are not awaiting a tipping point but instead are meeting fiduciary responsibilities by responding through partnership exploration and arrangements. **T**

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