**Hospital Affiliations and the Establishment of ‘Hospital Networks’**

Collaborations between Academic Medical Centers and Community Hospitals

Deborah R. Farringer, Esq. – Vanderbilt University
Amy Garrigues, Esq. – K&L Gates LLP

**Introduction**

Academic Medical Centers (‘AMC’ s) are increasingly affiliating with community hospitals in an attempt to create a larger community network and better position themselves in light of changing payment structures, declining volumes and increasing reimbursement pressure. There is a continuum of affiliation options between AMCs and community hospitals, with recent activity largely falling into one of the two ends of the spectrum: (i) formal ownership affiliations created by mergers, acquisitions, and joint ventures, and (ii) informal affiliations consisting of contractual affiliations and care coordination. In recent years, these informal, looser affiliations have become increasingly popular, as creative new models for partnerships arise. In deciding whether to affiliate, and what form an affiliation will take, AMCs must address a number of legal, financial, and practical considerations. Achieving a successful long term partnership will ultimately demand that the AMC have a clear and comprehensive understanding of both its own goals, as well as the goals of a prospective partner.

**Forms of Affiliation**

A number of AMCs and health systems continue to pursue the creation of hospital networks through mergers and acquisitions. The number of hospital mergers and acquisitions has been increasing in recent years, with one source citing that the number has risen...
approximately 165 percent from 52 in 2009 to 86 in 2011.\textsuperscript{1} AMCs have been a major player in these transactions. In 2010, according to Price Waterhouse Coopers, about 20 percent of health-related mergers and acquisitions involved an AMC.\textsuperscript{2} While the M&A method remains important, new and innovative models are emerging and increasing garnering attention in headlines. Certain challenges and disadvantages associated with full ownership, such as those related to integration and the assumption of liabilities, can be avoided through less formal affiliations. These new affiliation models can take a variety of forms, including franchise agreements, service-line or general affiliation agreements, or large scale collaborations. AMCs have a spectrum of options for informal affiliations reflecting various levels of financial and clinical integration of with their partner. These new models appear to be taking off as AMCs and other hospital system get more comfortable with their framework. 2012 saw a wave of activity with these looser affiliations, for example:

- In October 2012, BJC Healthcare out of St. Louis partnered with Memorial Health System (Springfield, IL), St. Luke’s Hospital (Kansas City, MO) and Cox Medical Center South (Springfield, MO) to form the BJC Collaborative, which is a large scale collaboration agreement involving no asset or capital contributions. The BJC Collaborative has indicated that it will be focused on sharing best practices, improving quality, and obtaining efficiencies through joint purchasing and other initiatives. The affiliation includes 30 hospitals with approximately $7 billion in annual revenue.

- In March 2012, Hackensack University Medical Center in New Jersey and North Shore-Long Island Jewish Health System in New York announced that they had entered a “strategic alliance” to share best practices and resources and work together on co-operative programs, ACOs, management programs, IT programs, affiliated federally


\textsuperscript{2} Price Waterhouse Coopers Report, The Future of the Academic Medical Center: Strategies to Avoid a Margin Meltdown, Health Research Institute, Feb. 2012.
qualified health centers, and referral arrangements for specialty care. The parties will stay independent, with separate boards and full responsibility over their own operations. The alliance is reported to cover 8 million residents, representing ~310,000 annual hospital admissions.3

- In July 2012, Wyoming County Community Hospital (N.Y.) unanimously approved a collaboration with University of Rochester Medical Center (“URMC”), the third recent collaboration for URMC. These affiliations are reportedly designed to allow URMC to improve specialty care and provide access to greater resources at community hospitals.4

- In August 2012, Memorial Health (academic medical center and healthcare organization in Georgia and South Carolina) and Novant Health (13 hospitals in North Carolina, Georgia, Virginia, and South Carolina) entered a strategic partnership involving a shared services agreement and supply chain, clinical engineering, IT, and clinical program collaborations. The two entities remain independent.5

- Also in August 2012, the University of California San Francisco Medical Center and Dignity Health announced that they entered into a memorandum of understanding to develop a partnership to integrate their healthcare systems without entering a full merger or acquisition.6

**Traditional Forms of Affiliation**

*Acquisition and Mergers*

Numerous market forces are putting pressure on AMCs to consider consolidation. There is a negative outlook toward future revenue growth. The Patient Protection and Affordable Care Act (PPACA) has put downward pressure on Medicare and Medicaid reimbursement rates and

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has signaled a move towards rewarding the coordination of care between primary care physicians and specialists. As a result, a number of AMCs are attempting to increase their network of primary care physicians. At the same time, PPACA is projected to lead to growth in low-revenue groups within the hospital patient mix. Government budget constraints are expected to lead to reductions in Indirect Medical Education and National Institute of Health funding.\textsuperscript{7} NIH funding is projected to be cut by 7.8\% in 2013, and IME funding is expected to be cut by 10\% in 2013, with projections that IME could be cut by up to 60\% in the future.\textsuperscript{8} At the same time a sluggish economy has suppressed philanthropic funding.

Hospitals are also facing additional costs and obligations, including a transition to electronic health records and meeting new quality standards under PPACA. The perception of top quality that AMCs have historically enjoyed has also been sliding lately, as seen by the decline in the number of AMCs on top hospital lists (which may be partially due to quality being tied to cost).\textsuperscript{9} Adding to these challenges is a difficult capital market, within which the hospitals with the most substantial capital needs to make themselves competitive may also incur the greatest challenges in raising significant funding.

However, complicating hospital acquisitions and mergers has been increasing pushback from the Federal Trade Commission ("FTC") and state Attorneys General ("AGs") on antitrust issues. Several deals in recent years have been either canceled or forced into court on this basis. For example, Reading Health System in Pennsylvania ("Reading") dropped their plans to acquire Surgical Institute of Reading, LP ("SIR") after the Pennsylvania Attorney General and the FTC

\textsuperscript{7} See Price Waterhouse Coopers Report, \textit{supra} note 2
\textsuperscript{8} \textit{Id.}
\textsuperscript{9} \textit{Id.}
announced plans to file a preliminary injunction. Reading operates a 737-bed hospital, and was looking to acquire SIR’s 15 bed clinic, specializing in ENT, orthopedic, spine, and general surgery procedures.\footnote{Press Release, FTC, FTC and Pennsylvania Attorney General Challenge Reading Health System’s Proposed Acquisition of Surgical Institute of Reading (Nov. 16, 2012). http://www.ftc.gov/opa/2012/11/reading.shtm} The FTC argued that the acquisition give Reading too much market share over specialized surgical procedures in the local area, increasing their market share to between 49 and 71 percent for the various procedures.\footnote{Id.} The AG noted that SIR charged rates “30-40 percent less” than Reading, and yet obtained similar outcomes for patients.\footnote{Id.} The AG also alleged that Reading was already offering discounts to commercial health plans that would exclude their competitors.\footnote{Reading Health System Halts Acquisition of Surgical Hospital, READING EAGLE, Nov. 19, 2012.} Less than a week later, Reading leaders terminated the deal, citing fears of the costs of litigation but maintaining that the deal would have reduced costs to consumers.\footnote{Press Release, FTC, FTC and Georgia Attorney General Challenge Phoebe Putney Health System’s Proposed Acquisition of Palmyra Park Hospital as Anticompetitive (Apr. 20, 2011), http://www.ftc.gov/opa/2011/04/phoebeputney.shtm.}

Phoebe Putney Health System’s (“Phoebe”) acquisition of Palmyra Park Hospital (“Palmyra”) in Georgia was also challenged by the FTC, and is currently under U.S. Supreme Court review. In 2011, Phoebe, which operates a 443-bed hospital in Albany, Georgia, moved to acquire Palmyra, a 248 bed hospital also located in Albany. In April of 2011, the FTC voted 5-0 to challenge the acquisition, arguing that the merger violates federal law by creating a monopoly and is likely to increase rates while reducing options and lowering quality of service.\footnote{Press Release, FTC, FTC and Georgia Attorney General Challenge Phoebe Putney Health System’s Proposed Acquisition of Palmyra Park Hospital as Anticompetitive (Apr. 20, 2011), http://www.ftc.gov/opa/2011/04/phoebeputney.shtm.} In December 2011, the 11th Circuit Court of Appeals upheld the acquisition, but only on narrow
grounds. Since Phoebe leases its rights to the hospital from the Hospital Authority of Albany-Dougherty, which approved the acquisition, Phoebe pursued a successful claim of state action immunity. In fact, the 11th circuit agreed with the FTC that the acquisition would “substantially reduce competition or tend to create … a monopoly.” The case is under U.S. Supreme Court review, but the main issue will again be the state action immunity question.

Finally, the FTC also recently ordered ProMedica to dissolve ownership of St. Luke’s Hospital in Ohio after the acquisition was found to be anti-competitive. ProMedica operated three general acute care hospitals prior to the 2010 merger with St. Luke’s, a previously independent general acute care hospital in Toledo. The FTC argues that ProMedica obtained a 60% market share for general in-patient acute care service in the Toledo area after the merger, and an 80% share of inpatient obstetrical services. ProMedica is appealing in the 6th Circuit Court of Appeals, arguing that the collaboration with St. Luke’s is a way to better coordinate care. The American Hospital Association (“AHA”) has filed an amicus brief in support of ProMedica, arguing that the FTC has ignored current market trends driving the need for hospitals to consolidate in order to survive.

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16 FTC v. Phoebe Putney Health System Inc., 663 F.3d 1369 (11th Cir. 2011).
17 Id. at 1375.
20 Id.
21 ProMedica Health System, Inc. v. FTC, No. 12-3583 (6th Cir. filed May 18, 2012); see also Robert Pear, Regulator Orders Hospitals to Undo a Merger in Ohio, N.Y. TIMES, Apr. 2, 2012.
22 Brief of Amicus Curiae American Hospital Association in Support of Petitioner, Promedica Health System, Inc. v. FTC, No. 12-3583 (6th Cir. filed May 18, 2012).
In addition to directly getting involved in acquisition deals such as those discussed above, state AGs have also begun inquiries looking into the role hospital acquisitions play in the health care marketplace. AMCs have come under scrutiny along with larger non-teaching health care institutions, in light of their size and specialty services. For example, in North Carolina, the AG made a statement that he will be investigating whether hospitals are artificially raising prices following mergers. The announcement shortly followed a newspaper investigation looking into whether hospital cost increases followed consolidation. In addition to working with the FTC, the North Carolina AG suggested that new legislation aimed at regulating the structure of future mergers might be a good remedy.

Similarly, the Massachusetts AG concluded in a 2010 investigate that high healthcare costs were tied to the market leverage of hospitals. Since then, the state AG has scrutinized several mergers, including recently the Partners HealthCare System – South Shore Hospital merger. While the AG office is looking into the competitive impact of the merger, Partners is emphasizing that the merger is about integrating knowledge and improving efficiencies, which should ultimately reduce costs.

In addition, California’s AG has subpoenaed several prominent hospital chains, as well as insurers, in an effort to determine whether those hospitals violated antitrust laws by improperly raising prices post-merger. The AG investigation is focused on whether after the merger the hospitals gained enough market leverage to increase prices in a way that violates anti-trust laws.

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24 *Id.*


The AHA has argued that the studies the AG is relying on are flawed because they did not consider all of the factors that can lead to increased prices, such as consumer preference. 28 Furthermore, the hospitals and the AHA continue to highlight that national trends in health care are making these types of mergers a necessity for providers.29

Beyond antitrust issues, there are additional significant legal considerations in a hospital acquisition, including compliance with federal and state fraud and abuse laws. In particular, the acquiring company will investigate physician contracts and other areas prone to creating issues under the Stark Law. In 2010, CMS introduced the Stark Law Self-Referral Disclosure Protocol (“SRDP”), which allows providers to voluntarily disclose potential violations of the Stark Act. These disclosures have often become a condition to close in mergers and acquisitions, and the filing clarifies the responsibility for any pre-closing issues and the amount of any indemnification escrow. In a March 2012 Report to Congress, CMS reported that they had received 150 voluntary disclosures in the first two years, 125 of which came from hospitals.30 However, only seven of those disclosures had been settled at the time of the report.31

An acquisition or merger also has practical challenges beyond the legal arena. A successful merger requires careful coordination of care, including clinical integrations and combining HIT. There may be cultural differences that will require building trust to integrate the staff. There may be receptivity issues on both sides. AMC physicians may have to be encouraged to commute to community hospitals, and the community hospital clinical staff may

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29 Id.  
31 Id.
be concerned about the change. AMCs may take on the historical liabilities of the target. Finally, there could be concerns about a dilution of the AMC brand, especially if there is difficulty integrating the cultures and improving quality factors within the community hospital. The fact that community physicians now carry the AMC name (and at times, receive a higher salary) may not be viewed favorably by the AMC medical staff.

If these challenges can be met, however, a merger between an AMC and a Community Hospital can bring substantial opportunities. For AMCs, it allows them to expand both their brand and their network, increasing their geographic footprint, and allows the AMC the greatest ability to exert control over the hospital. It can improve their economies of scale to help lower costs. And it can create additional opportunities for the AMC to participate in Accountable Care Organizations (“ACO”s) or other CMS and private payor innovation programs, particularly if the AMC has not historically had extensive relationships with primary care physicians. For the community hospital, it gains access to the capital and bond markets necessary to make cost and quality improvements, and access to the numerous other brand, facility, research, and specialist physician resources possessed by the AMC.

Based on data from Becker’s Hospital Review, since 2011, AMCs have either finalized acquisitions or are currently in acquisition talks in 21 states. Some recent examples:

- In January 2012, Beth Israel Deaconess Medical Center acquired Milton Hospital in Milton, Massachusetts, an 83-bed acute care hospital. The CEO stated that there “will

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always be a place for AMCs to do what can’t be done anywhere else. But we also recognize that there’s a lot of care that can and should be provided in the community.”

In September 2012 after state approval following an antitrust review, Yale-New Haven Hospital acquired Saint Raphael Hospital in New Haven, Connecticut for $160 million. Saint Raphael was a 511-bed community hospital that also has a teaching component. The transaction reportedly allowed Yale greater access to patient beds, while providing the underutilized Saint Raphael Hospital with needed capital. The merger created a two campus hospital system with 1,519 beds. The merger has been described as “a coming together of our respective skills and resources…[this merger] means that one hospital can now guide you completely from diagnosis to treatment to recovery.”

In December 2012, University of Maryland Medical System (“UMMS”) acquired St. Joseph’s Medical Center (“St. Joseph’s”) in Towson, Maryland. St. Joseph’s is a 263-bed acute care bed hospital. The leaders within St. Joseph’s see the acquisition as a way to move away from negative publicity that began three years ago when it was alleged that a former cardiologist was unnecessarily placing stents in patient’s arteries; the controversy reportedly resulted in a 25% loss in revenue. UMMS has agreed to follow the religious principals and beliefs of the Catholic Church in its operation of St. Joseph’s.

In December 2012, Baylor Health Care System, out of Dallas announced their plans to merge with Scott & White Healthcare, out of Temple, Texas. The merger would combine 42 hospitals to form a health system valued at around $8 billion. The location of the systems means that there is no overlap between the hospitals, which leaders say

33 Robert Weisman, *Adding Milton Hospital, Beth Israel Enters New Era*, BOSTON GLOBE, Jan. 3, 2012. Note that Beth Isreal Deaconess’s parent holding company is CareGroup, which also serves as the parent holding company for Beth Israel Deaconess Hospital-Milton, Beth Israel Deaconess Hospital-Needham, Mount Auburn Hospital, and New England Baptist Hospital. While the affiliation was originally formed for purposes of care delivery, it now describes itself as a confederated model in which they jointly borrow and purchase certain services, but largely operate in a decentralized manner. See [http://www.bidmc.org/AboutBIDMC/AffiliatesandPartnerships/CareGroup.aspx](http://www.bidmc.org/AboutBIDMC/AffiliatesandPartnerships/CareGroup.aspx). This is an example of another potential mode of affiliation among hospitals loosely connected through a parent holding company.

34 Yale-New Haven Hospital Website, We are One, www.ynnh.org/src/we-are-one.aspx.

will allow them to increase their scale and efficiency without worrying about internal competition between hospitals.\textsuperscript{36}

Additionally, in a non-cash transaction in April 2011, All Children’s Hospital in St. Petersburg, Florida, a 259-bed freestanding pediatric hospital, joined the Johns Hopkins Health System. The CEO stated that the integration will allow them “to expand their role as a leader in medical discoveries that improve the health of children” through “more education, research, and clinical opportunities for our pediatric facility.”\textsuperscript{37} Since then, All Children’s has, among other things, developed a new medical residency program at All Children’s that will commence in July 2014, and hired a new Director of Research.\textsuperscript{38}

\textit{Joint Ventures}

AMCs may alternatively seek to partner with a community hospital by entering into a joint venture with a hospital or with a service line within a health system. Joint ventures offer access to capital and shared financial risk, but less control as compared to pure ownership. Antitrust issues should also be considered when exploring a joint venture option. If the joint venture partners are competitors or the joint venture competes with an existing AMC service line, then firewalls may be required from an antitrust perspective which limits integration and which can also present compliance challenges.


\textsuperscript{37} Richard Martin and Kris Hundley, \textit{All Children’s Hospital to Join Forces with Johns Hopkins Health System}, \textit{Tampa Bay Times}, July 21, 2010.

\textsuperscript{38} Press Release, John Hopkins Children Center, All Children’s Announces New Pediatric Residency Program (July 31, 2012); Press Release, All Children’s Hospital, Dr. Neil Goldenberg Joins All Children’s Hospital as Director of Research (Sept. 12, 2012).
AMCs also must consider fraud and abuse regulations and ensure that the venture is carefully structured to ensure fair market value buy-ins. Additionally, if the venture is a non-profit is partnering with a for-profit entity then there will also be tax considerations for the non-profit entity. Finally, if the parties are attempting a provider-based joint venture, then the joint venture must be structured to comply with the federal provider-based regulations as well.

As an example, in January 2011, Duke University Health System partnered with LifePoint Hospitals to form DLP Healthcare, LLC (Duke/Lifepoint), a joint venture aimed at partnering with community hospitals. The venture is principally owned and operated by LifePoint, which has experience operating community hospitals in 17 states. Duke only has a 3% ownership state in the venture. Instead of a large ownership stake, Duke has stated that it is using the venture as a means to increase its hospital footprint, while bringing its resources and knowledge on hospital quality to the community hospitals that are acquired. Since forming, the venture has acquired five hospitals in North Carolina, Virginia, and Michigan.

Shands Healthcare in Florida is an example of using joint venture model in another way – to partially divest itself of full ownership. It had previously acquired three community hospitals and has used a joint venture with Health Management Associates to divest itself of full ownership. This allowed Shands to maintain 40 percent ownership and affiliate networks, while being able to move away from being principally responsible for the day to day operations of the community hospitals.

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[40] Id.

If an AMC does not want an ownership interest, an alternative approach is to set up a management relationship, wherein the AMC agrees to manage a community hospital or a particular service line within the community hospital. This allows the AMC to bring in additional revenue by selling their management experience without having ultimate control over the community hospital. The AMC can spread its overhead costs and improve the education and experience of their staff. The community hospital gains increased access to the management experience and resources of the AMC. Furthermore, a management agreement can be a good stepping stone for establishing future, additional collaborations.

However, a management relationship has many of the same legal considerations that joint ventures face. Management services arrangement must be carefully structured around FMV payments to avoid fraud and abuse issues, and information-sharing must be carefully monitored to avoid antitrust issues. In addition, the ultimate lack of control by the AMC can be challenging if compliance or other issues arise (e.g., if the manager feels a SRDP is warranted but the managed hospital disagrees or if the managed hospital achieves financial gains by adopting a lower staffing ratio). The informal nature of the relationship can also make it difficult for the AMC to exert enough control to solve any issues or problems, which can also be exacerbated by if the community hospital is located a significant distance from the AMC.

Emerging Models

Franchise approach

In a franchise approach, the AMC provides a package of good and services to a community hospital in exchange for an annual fee. These packages can include assistance in areas such as policies and procedures, standardization of protocols, clinical direction, quality assurance activities, credentialing, and recruitment of physicians. It can also include the benefit of having rights to use the AMC’s name and/or include references on signage. The community hospital can use this model to redefine its image in addition to having access to the resources and the expertise of the AMC. This model attempts to leverage the value of the AMC brand. In a PWC study, 59 percent of consumers indicated that they were likely to seek treatment from a community hospital if it was associated with an AMC.\(^{43}\)

For the AMC, it can use this model to increase its geographic footprint through branding, with minimal investment. It also opens the lines of communication with the community hospital for future, more expansive collaborations. Also, it is an immediate source of revenue in exchange for helping to develop local capabilities. The challenge for the AMC is that as it spreads its brand name, its image can be diffused by its use in settings over which the AMC has limited control. If the community hospital fails to improve, the AMC’s name will likely be tied to that failure. An AMC has to be careful to manage expectations of the community hospital and the local public in the ability of this model of affiliation to achieve the desired level of results, in order to potentially avoid any legal challenges related to a failure to obtain certain results. The

\(^{43}\text{See Price Waterhouse Coopers Report, supra note 2}\)
community hospital, on the other hand, may face tension between retaining their own autonomy and decision-making capacity while conforming to the franchise requirements.

Affiliation Agreements

Increasingly, AMCs and community hospitals are entering into affiliation agreements based on particular service lines. Under this agreement, the parties can work to designate certain types of care to the facility best suited to provide that care. Some of the specialty or services lines in which AMCs appear to be developing such affiliations include telemedicine, neonatology, cancer care, stroke care, specialized surgery, and trauma. These agreements have the potential to manage care in a more efficient manner for the patient. In addition, for the AMC it is an opportunity to expand its network with minimal investment, if any, and can provide additional training sites for residents. In particular, the AMC may be able to increase its access to a primary care physician network, which provides greater opportunities for ACOs and other innovative partnerships. For community hospitals, they may be able to significantly improve access to specialty care and clinical resources for their patients, while remaining independent.

The key legal consideration for these types of arrangements is ensuring compliance with fraud and abuse laws, in particular the anti-kickback statutes. The arrangement should be structured in a way so that all services are performed at fair market value, and the payment or services are not provided in exchange for generating additional referrals for the AMC. Other operational challenges include motivating the clinical staff of both parties to buy into the arrangement and the practicalities of designing an agreement that accomplishes the goals of each party while maintaining an informal structure.
A recent example of a service-line agreement is the affiliation between Steward Health Care Systems and Partners HealthCare System to transfer ED trauma patients. Steward and Partners are the largest health care providers in Massachusetts. In the arrangement, Steward agreed to refer their Level 1 trauma patients to Partners, while Partners agreed to assist Steward in achieving Level 3 trauma designation. The deal provides a significant increase in referral volume for Partners. Steward currently sends Level 1 trauma patients to five different centers in Boston; after the affiliation, they will all be referred to Partners hospitals unless the patient has a different preference or the EMT takes the patient directly from the scene to a different hospital. For Steward, in addition to demonstrating ties with high-end institutions, developing its own trauma designation can help set it apart from other nearby community hospitals. In the case of Steward-Partners, the Massachusetts AG is reviewing the details of the agreement, although the AG has not yet made a comment on the arrangement.

Another recent example was a Cardiologist Affiliation Agreement between Christ Hospital in Ohio and Southwest Regional Medical Center in Ohio. Under the agreement, cardiologists within Christ Hospital’s practice would begin treating patients at SWRMC. The agreement was intended to expand to oncology and orthopedics departments. However, within nine months Christ’s CEO departed and Christ terminated the arrangement, citing a difference in opinion about the role the rural SWRMC would play. This example highlights the importance of ensuring open communication and setting expectations well in advance of implementation of an agreement.

45 Robert Weisman, Steward Strike Trauma Care Alliance with Partners, Strengthening Ties Between the Two Largest Health Care Providers in Massachusetts, BOSTON GLOBE, October 18, 2012.
46 Id.
Large scale collaborations

There a significant creative space for AMCs to experiment with different types of large scale collaborative agreements. Several types of agreements have been developed in recent years, as this category of arrangements continues to evolve. The collaborations can be based around specific goals, such as achieving operating efficiencies, or around more broad healthcare alliances. For example, a joint purchasing program focuses on improving non-labor expenses through improved economies of scale. This greater volume can allow for the potential for cost savings and efficiencies, as well as greater standardization of supplies. Alternatively, the parties may choose to develop a broad platform for sharing respective areas of expertise, such as support services and IT. Large scale collaborations often involve more than two parties, with all parties seeking to improve quality and efficiency by identifying the group’s best practices.

The BJC Collaborative is an example of a recent large scale collaboration agreement aimed at increasing quality of care and reducing costs. It was formed in October 2012. BJC Healthcare out of St. Louis partnered with Memorial Health System (Springfield, IL), St. Luke’s Health System (Kansas City, MO) and Cox Medical Center South (Springfield, MO). The collaboration stretches 3 states and includes 30 hospitals totaling $7B in combined annual revenue. In the collaboration, leaders from each system joined to form an Operating Committee with a goal of increasing the quality of care and lowering healthcare costs. In addition to joint purchasing initiatives, the collaboration also aims to partner on physician recruitment, staff training and education, clinical skill training, financial services, and other best practices. The

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collaboration to date does not involve any asset or capital contributions, and the hospital leaders have stated that a merger was never contemplated, nor was any hospital in distress such that anyone was looking for a merger.\footnote{Beth Kutscher, \textit{Bang Without the Buck? Bypassing Merger, Four System Look for Buying Power, Reduced Costs with Collaboration}, Modern Healthcare, Oct. 27, 2012.}

In another example, the University of Iowa announced in June 2012 that it was launching the University of Iowa Health Alliance with several other entities, including Mercy Health Network, Genesis Health System, Mercy-Cedar Rapids, and UI Health Care. In all, more than 50 hospitals and 160 clinics are involved in the affiliation.\footnote{Press Release, University of Iowa Health Care, Iowa Health Care Organization Launch New Partnership (June 28, 2012).} Similar to the BJC collaboration, no actual mergers or change of control or assets was included in the deal. Instead, the focus is promoting “clinical integration and care coordination,” using in part comparative data to find and share best practices.\footnote{Id.} One of the main components of this arrangement is improving the continuity of care that an individual patient experiences, though coordinating records and visits between the various entities. However, the collaboration is also looking to coordinate in areas such as developing universal performance metrics, developing comprehensive education programs, sharing IT costs, and working on developing ACO initiatives.\footnote{Id.}

The number and diversity of stakeholders in these larger collaborations pose particular challenges. As the partnership involves more services and a larger group, the ability to maintain trust and effective collaborate may become unwieldy. Also, these types of groups will need to ensure information sharing is in compliance with antitrust safeguards given that the parties
remain separate entities. There is a tension between utilizing open communication to best spot efficiencies and being at risk of falling into the category of market coordination.

**Considerations in Selecting an Affiliation Model**

Ultimately, these new models for participation allow an AMC to create and tailor an affiliation with its needs and goals. The first step, then, for an AMC seeking an affiliation is to make a careful evaluation of its goals. If hospital system needs financial stability, access to capital, or is looking for full physical or clinical integration, then a more formal relationship may be preferable. For other goals, such as sharing best practices, expanding a brand or service line, or improving the ability to recruit medical staff, a health system can structure a less formal relationship. Less formal relationships are especially important for systems seeking to maintain autonomy. Any affiliation is a two-way street, so being cognizant of a potential partner’s goals is also vital for a lasting relationship. This includes, for example, being clear on the other parties vision for governance, level of integration, and budgetary controls. Finally, legal and regulatory considerations must inform the structure and terms of the deal. Anti-trust, fraud and abuse, and tax considerations are critical considerations and will influence the shape of a successful affiliation.

**Case Study: Vanderbilt Care Coordination Grant**

In an example of the means by which AMCs seek collaborations with community hospitals under the affiliation models cited above, Vanderbilt University Medical Center (“VUMC”) has recently entered into affiliation agreements with several community hospitals in the middle Tennessee area, including Maury Regional Medical Center, NorthCrest Medical
Center, and Williamson Medical Center (each, an “Affiliate” and collectively, the “Affiliates”).

Under such affiliations, the parties are undertaking collaborative efforts to expand medical services provided by the community hospitals to residents of the particular service area through an enhanced level of integrated care and the application of scientifically informed and best evidenced-based care. The affiliation agreements serve as a master agreement to define services and collaborations contemplated by the parties, the details of which are spelled out in separate written agreements. In order to encourage the parties to work together, the agreements include a provision setting up a governance structure whereby the parties agree to discuss in advance the establishment of any new facilities, clinics, or operations. Some examples of programs and services that have already been established under the new affiliation agreements are: (1) the formation of a joint venture with Maury Regional Medical Center for the operation of a radiation oncology center; (2) a professional services agreement whereby VUMC operates the cardiac surgery program for Maury Regional Medical Center; and (3) a professional services agreement whereby VUMC physicians provide outpatient and inpatient services for rheumatology and endocrinology on behalf of NorthCrest Medical Center.

**CMS Innovation Grant**

It was VUMC’s unique relationships with these Affiliates and VUMC’s goal to discover and foster new and innovative approaches to care coordination that prompted it to apply for one of the Innovation Grants from the Center for Medicare & Medicaid Innovation (“CMS

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53 The hospitals mentioned above all signed affiliation agreements in the fall of 2011. Since such time, VUMC has also signed affiliation agreements with Cookeville Regional Medical Center and Jackson-Madison General Hospital. Maury Regional Medical Center is a county-run hospital system with 3 hospitals (one primary hospital with two critical access hospitals) in counties to the south of Nashville, Tennessee. NorthCrest Medical Center is a 501(c)(3) Tennessee non-profit hospital located in a county to the north of Nashville, Tennessee. Williamson Medical Center is a county-run hospital system with one hospital located in a county immediately south of Nashville, Tennessee.
Innovation Center”). The CMS Innovation Center describes awards like those given to VUMC as supporting “local projects in communities across the nation that aim to deliver better care and better health at lower costs. These efforts are directed at those enrolled in Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP), particularly those with the highest health care needs.”\footnote{Centers for Medicare and Medicaid Innovation website (accessed Jan. 1, 2013) available at www.innovations.cms.gov.} At its heart, the project for which VUMC was awarded the Innovation Grant (“Project”) aims to provide better disease management and continuity of care for patients suffering from diabetes, hypertension, and congestive heart failure. Consistent with the goals of the CMS Innovation Center, VUMC is working with the Affiliates in order to provide these services in community settings in Nashville, Tennessee and its surrounding counties.

In June 2012, VUMC received preliminary notice of an award of $18.8 million to be provided over a three year period to VUMC and its Affiliates for development and implementation of the Project.\footnote{Press Release, Vanderbilt University Medical Center, Vanderbilt and affiliates receive $18.8 million innovation award to improve health care, reduce costs for chronic conditions, available at http://www.mc.vanderbilt.edu/news/releases.php?release=2458 (accessed Jan. 2, 2013).} The primary mechanism to be used in the Project is the MyHealthTeam model (“MHT Model”), which is intended to establish a new model of care delivery that assures quality of care and improved health status. The new MHT model was developed in an attempt to address the following issues facing health care in the United States: (1) achieving our potential for quality of care and improved health status; (2) rising prevalence of chronic disease; (3) achieving greater consumer engagement; (4) addressing the mismatch between supply and demand for health care services, especially primary care; and (5) addressing financial pressures mandating less-costly and more efficient care delivery systems. MHT endeavors to address each of these issues through a combination of new technology resources
and a new team-centered staffing approach, focusing on care coordination and patient engagement.

The Medicare and Medicaid programs spend more per capita on treating patients with chronic conditions, including congestive heart failure, hypertension, and diabetes, than patients without chronic conditions. There is a clear necessity to develop new methodologies to provide more coordinated care to patients suffering from chronic conditions in a way that can also help bend the cost curve and make health care expenditures more manageable for Medicare and Medicaid. With that backdrop, the MHT model seeks to improve disease management, reduce mortality, reduce hospitalizations and readmissions, all in a way that will help to lower costs and provide better quality care for the patients. In order to establish this, the first thing that the MHT model has set out to do is create a strong relationship among primary care providers, the patients, and a care coordinator to assist with disease management. It does this through the use of health information technology (“HIT”) that supports the work of the team responsible for the care and creates an opportunity for interaction with the patient. Implementation of this model incorporates several technology components that are aimed at making the tool effective and easy to use, which include: (1) multiple means of patient identification; (2) rapid enrollment; (3) consistent patient stratification (e.g., personalized medicine); (4) creation of an achievable personalized, evidence-based care plan for every enrolled patient; (5) employment of advanced

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56 CMS states that the national per capita costs go up exponentially based on the number of chronic conditions of the beneficiary. According to Medicare Spending and Utilization Metrics, the average national per capita cost for beneficiaries with 0 to 1 chronic conditions is about $2,097 vs. an average of $5,677 for beneficiaries with 2 to 3 chronic conditions, $11,628 for beneficiaries with 4 to 5 chronic conditions, and $31,543 for beneficiaries with 6 or more chronic conditions. Centers for Medicare and Medicaid Services website, Chronic Conditions Dashboard, available at http://www.ccwdata.org/business-intelligence/chronic-conditions/index.htm (accessed Jan. 3, 2013). In Tennessee, the Medicaid program spends approximately $4,180 per beneficiary with congestive heart failure (compared to a national average of $3,620), approximately $2,150 per beneficiary with hypertension (compared to a national average of $2,180), and approximately $3,560 per beneficiary with diabetes (compared to a national
informatics tools to enhance and encourage communication between providers and patients; (6) continuous updating and improvement from design processes; and (7) continuous examination of the health care team composition to lower costs and assure quality.57

The mechanics of the MHT model are as follows. Patients are identified for participation in the program based on their disease cohort and then further stratified by disease control status and level of co-morbidities. Once enrolled, certain data sets are extracted from the patient’s medical record to create what is being referred to as a “community record.” The community record is held in a secure portal and is accessible by the patient’s physicians (across multiple sites) and the patient’s care coordinator. The data sets are updated as new information comes in and/or progress is made. The data sets include certain clinical characteristics (e.g., immunization record, discharge summary, problem list, diagnostic radiology and lab results, medication lists, etc.), health care transaction data (e.g., emergency room visits, hospitals visits, 30-day re-hospitalizations, other billable services, etc.), and financial data (including socio-demographics, region (urban or rural), and insurance information). All data is pulled from the patient’s medical record (including financial data related to the medical record) and not from claims data or health plan data. This is significant because the use of medical record data helps to eliminate potential bias or skewing of the information on the basis that it will include all patients, not just those with insurance or an ability to pay. The model includes an ability for the patient to access his/her own data and become more involved in self-monitoring and his/her own treatment plans utilizing the HIT tools available.

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57 Vanderbilt University’s application to CMS Innovation Center for award of grant.
Involvement of the Affiliates

One aim in utilizing the affiliate structure of VUMC is the intention and hope that the MHT model that is being implemented and explored through the Project is scalable on a national basis because it does not involve the efforts of a closed system, but involves patients seeking care from multiple independent institutions across both rural and urban settings aligned through affiliation agreements. VUMC does not have ownership or control over any of the Affiliates, all of which are independently owned and operated (in many cases by a local government entity). Thus, this model should be able to be replicated on a nation-wide basis without a requirement for joint ownership or control, which can be costly, and thus, rate limiting.

Utilizing the MHT model across Affiliates also seeks to create greater quality of care provided to patients in the Middle Tennessee region who currently seek care in multiple locations. There are many patients who are already today patients at both VUMC and an Affiliate. For example, VUMC’s medical group constitutes approximately forty percent (40%) of the current medical staff of Williamson Medical Center and thus there are many patients who have received care both at Williamson Medical Center and at Vanderbilt University Hospital. Utilizing the MHT model, specialists and primary care physicians at both hospitals will have access to information regarding a particular patient regardless of the location in which the services were provided (including in the patient’s home), along with access to a care coordinator who will be able to monitor and track the patient’s care among various providers and institutions.

Although the affiliate structure is one of the advantages of being able to scale the MHT model on a national level, this structure also presents some challenges because of (a) the inherent cultural differences that are often present between AMCs and community hospital systems and
(b) the increased legal, compliance, and reputational complications related to the affiliation structure. Culturally, AMCs and community hospitals have very different perspectives and operations, and undertaking these sorts of collaborations presents challenges for both parties. In the case of VUMC, as one of the leading recipients of NIH grant funding, VUMC has a heavy emphasis on teaching and research and is often the single source provider in the region for certain highly specialized care as a result of its research focus. This, in turn, can lead to a higher cost structure to provide appropriate and medically necessary care to patients. VUMC is also a largely closed system with all members of the medical staff either employed or faculty of VUMC’s School of Medicine. Employed physicians split their time between research, teaching, and clinical practice. There is a heavy emphasis on the provision of evidence-based medicine, and technology tools are widely used throughout the system, with a common electronic medical record, electronic prescribing system, and electronic disease management tools. The Affiliates, on the other hand, largely have traditional open staff models where physicians in private practice working in the community have privileges to provide services at the hospital, but they are not employees. This means that while a particular Affiliate may have an electronic medical record for its hospital patients, such record is not incorporated into any outpatient physician records (as the case of VUMC) and all such records (outpatient and inpatient) vary greatly among practices (e.g., some have paper records, some electronic medical records). The heavy emphasis in community-based settings is on the provision of clinical care to the patient, with less emphasis on research initiatives or teaching.

Another cultural challenge that has arisen for VUMC as its affiliate relationships have developed relates to the fact that there is often a sense of territorialism or competitiveness in trying to accomplish collaborations without a merger or acquisition. For example, there may be
a fear on the part of the Affiliate and/or its physician medical staff that VUMC is trying to take over services in the community or trying to encourage patients to come back to VUMC’s main campus for services, as opposed to seek care at the local hospital. In the reverse, VUMC may have to address internal fears that it will be difficult to draw new hires and new recruits into an academic setting if they can go into a community setting, but still have opportunities to interact with and affiliate with VUMC. These issues are unique to a structure whereby all parties attempt to remain autonomous, but work together towards a common goal.

As discussed in greater detail above, each model for collaboration presents its own set of unique legal and compliance challenges. Regarding VUMC’s experience in connection with the affiliation model, trying to accomplish meaningful integration in a way that will provide for better continuity of care and a better patient experience has presented many obstacles. Unlike an acquisition or merger with an existing hospital (in which case the AMC can implement a common EMR, common protocols and procedures, common platforms, management of referrals within systems), an affiliate structure does not allow the creation of open access fully integrated medical records or common protocols and procedures (including staffing models) in the same way as a system that is owned. It is for this reason that so much of the MHT infrastructure is focused on how to create a common record that is accessible to all. As the model is explored further, especially outside of the initial grant cycle, the parties will have to pay special attention to any technology infrastructure, or other goods, services, or anything of value that is being provided and maintained by VUMC or others to ensure compliance with the Federal Anti-kickback statute and the Stark Law (as it relates to individual physicians). To the extent that benefit is realized, the parties will have to assure that the goods or services are being provided at a fair market value rate and meet all applicable safe harbor or exception criteria, as necessary.
Many of the same risks and challenges posed above to affiliate relationships are present with the arrangements that VUMC has established with the Affiliates. Despite all of those challenges, the structure has thus far been a successful model for VUMC and the Affiliates in working together to, among other things, provide greater access to care in rural areas, enhanced services in the community, and better coordination of care for patients from a multitude of providers. The Project will be a good test case to work through some of the pitfalls and obstacles with the affiliate model, and hopefully serve as a model for other systems who might not have the capital, bandwidth, or ability to collaborate through other means in an effort to develop and implement high quality care for all patients throughout the community in a cost efficient manner.