A Healthcare Leader's Guide to Successful Mergers & Acquisitions

a compendium of insights

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JUNIPER ADVISORY

A Healthcare Leader's Guide to Successful Mergers & Acquisitions: a compendium of insights

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To our partners, Lindy and Sarah – thank you for the support

To our fathers, Jamie and Jeff – your guidance and inspiration made this book possible

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Preface

The book that follows has been nearly a decade in the making. With our colleagues and co-authors, we have written articles on almost every aspect of health system mergers and acquisitions. These range from defining the roles of Boards and management teams when pursuing business combination transactions through the technicalities of alternative structures. As we travel the country assisting our clients, we regularly find ourselves sharing these articles. When we do, we typically get requests for more. This led us to recognize the need for a compendium, a manual for hospital executives and Board members to use as they evaluate and execute strategic transactions.

Because the articles that make up this guide were each written by different combinations of authors to stand on their own, the style varies from chapter to chapter and there is some redundancy of material. We believe, however, that the depth and range of content included in this book compensate for that awkwardness. We expect that our readers will choose to use this guide in different ways. Some will read from cover to cover while others will read single articles or chapters as questions and issues arise. We have done our best to organize the content in a way that will meet the needs of both kinds of reader.

Many people have worked hard to produce the compendium which follows. The contributing authors are acknowledged at the beginning of each article and their brief bios can be found at the end of the book. It has been a privilege of ours to work with each of these talented professionals. While they are separately recognized for their contributions as authors, we would also like to specifically thank our colleagues Andrew Blank and Alex Normington here. Without their assistance in organizing and accumulating these articles, designing layouts and incorporating edits, the book that follows would still be in process.

Assembling this material has been a labor of love. We hope it can be useful to inform decision-making and aid those navigating a changing industry.

Jordan Shields and Rex Burgdorfer, *Juniper Advisory*

Foreword

Over the course of my career, mergers and acquisitions have impacted the vast majority of hospitals in the United States. Whether directly through system formation or indirectly as standalone hospitals struggle to compete with ever larger and more integrated neighbors. Reasons for entering into business combinations have differed over time. The constant throughout all cycles and environments, however, is *change*. *Change* in the 1990s came in response to the consolidation of managed care companies. *Change* in the 2000s was caused by the housing and financial crisis. Today, *change* stems from the myriad of structural and economic effects of Healthcare Reform. Tomorrow, *change* will be driven in part as providers respond to the COVID-19 pandemic.

Despite the prevalence of change-of-control strategies, M&A in the hospital sector remains largely a cottage industry. It is significantly more fragmented than comparable industries, i.e., those that are capital intensive and regulated.

Unlike the corporate world, large investment banks tend to service non-profit hospitals from the public finance department, in an underwriting capacity. M&A departments generally only advise equity sponsored hospital systems. Consultants meanwhile provide a host of important solutions for non-profit hospitals systems, e.g., software tools, planning, revenue cycle, operations, service line decisions, IT implementations, and the like. Bankers experienced in the unique aspects of non-profit, acute-care M&A are rare. Like many apprenticeship fields, a high volume of 'on-the-job' experience is irreplaceable.

The book that follows is a compendium of articles published by Jordan Shields, Rex Burgdorfer, their colleagues at Juniper Advisory

and other dedicated healthcare M&A experts. Information is drawn from decades of experience working with several hundred health systems.

Anyone who has lived through a merger or acquisition can attest to a transactions' complexity. As a result, topics in the book are highly varied, including Board-level Governance issues, M&A tactics, capital structure considerations, process design, valuation methodologies, accounting customs, legal issues and best practices regarding stakeholder communications.

The authors provide both a commonsense business person's summary of topics, as well as a technical analysis of more detailed issues. Many expert contributors are executives that I have interacted with in my capacity as founder and president of The Becker Review. Becker's newsletters and conferences have become the industry standard for boards and management teams to share ideas. It became clear to me that industry consolidation to improve the efficiency and performance of this country's hospital systems is inevitable.

Research in this book is drawn from 'on-the-ground' practical experience assisting buyers and sellers of healthcare businesses. The content can be read either on a select article and chapter basis or continuously as a whole. I am confident that anyone involved in a leadership capacity at a hospital system, whether in a senior management or Board role, will find something interesting, relevant, and helpful in this volume.

Scott Becker, ***Founder and Publisher - Becker's Healthcare***

I. A Unique and Evolving Industry

Margin Pressure, Part I

By Dave Johnson and Jeff Jones

A host of market-driven and regulatory forces are fundamentally challenging traditional acute care operating models. These include a higher governmental payer mix, more discerning commercial buyers, more risk-based contracting, new competitors, changing consumer behaviors, and a dramatically shifting regulatory environment.

Together, these forces will make the coming decade the most challenging for hospitals and health systems since the 1990s. Unlike the 1990s, the solutions needed to meet current market challenges will require dramatic improvements in operating efficiency, and fundamental changes to health system business models.

Enlightened health system leaders will use this "calm before the storm" period to reposition their companies so they can compete more effectively by delivering higher value care services.

The Bond Rating Fallacy

Unlike for-profit companies, non-profit health systems operate for their communities' benefit. Non-profit companies cannot access equity funding or distribute earnings to shareholders. They fund investments through operating cash flows, debt, investments and charitable contributions.

As a consequence, non-profit health systems that actively raise debt in the capital markets carry high levels of cash and investments on their balance sheets. Strong balance sheets lead to higher bond ratings and lower interest rates. In its report, Fitch noted that balance sheet ratios are at their highest levels since the 2007 Great Recession.

By design, rating agencies evaluate the individual credit standing of non-profit hospitals and health systems based on their ability to repay indebtedness, not their longer-term competitive positioning. Their horizon is short, just two years.

Strong balance sheets combined with increasing near-term service payments justify their collective assessment that the non-profit healthcare industry's outlook is stable. Bond payments are secure for now. Immediate bond defaults are not a credit concern.

Given their robust bond ratings, non-profit health systems appear stronger than they really are. They operate capital-intensive, low-margin facilities that require highly skilled workers. They are vulnerable to new, more efficient competitors that deliver better outcomes at lower costs.

Dynamic forces are reshaping the healthcare industry's supply demand relationships in ways that fundamentally challenge traditional health system business models. This happened once before, during the 1990s, and forced many hospitals and health systems to their knees.

It is instructive to revisit the 1990s to examine how hospitals stumbled and then recovered. Beginning in the early 2000s, a massive infusion of new provider revenues triggered industry resurgence. History will not repeat itself.

Throw-back to 1999

During the 1990s, healthcare expenditures remained relatively flat. For the first and only time since World War II, healthcare expenditures grew at the same rate throughout the decade as the overall economy.

Throughout the 1990s, a mix of forces slowed the industry's previously high growth rate. The most important was the emergence of widespread managed care contracting through health maintenance organizations (HMOs). HMOs received fixed monthly payments to manage the care of their subscribers.

HMOs employed primary care physicians (PCPs) as gatekeepers to guide access to acute treatments. While this approach did reduce unnecessary utilization, it also incentivized PCPs to restrict access to

necessary care and often forced members to receive care at lower-cost institutions.

As a result, hospitals and health systems saw their revenues and profits diminish. In response, many formed their own insurance companies and/or employed physicians, notably PCPs, to increase their referral volume. In theory, this vertical integration enabled health systems to control a higher percentage of healthcare expenditure.

Most of these investments, however, proved disastrous. Hospitals and health systems deployed excessive capital to buy physician practices when they lacked the capabilities to manage the utilization of those practices. The passage of the Balanced Budget Act in 1997, which cut governmental payments to hospitals, amplified operating pressures.

By the late 1990s, many providers were bleeding red ink. Moody's coined the term "century club" to describe health systems with operating losses exceeding $100 million. Bond rating downgrades exceeded upgrades by a wide margin. Some organizations risked insolvency.

When their future appeared at its most bleak, market dynamics for hospitals suddenly improved. Consumers seethed with anger over HMOs' lengthy, bureaucratic and depersonalized care denials. Most HMOs folded. At the same time, federal spending restrictions imposed by Congress in 1990 and 1997 expired. With the federal budget in surplus for the first time in decades, the Centers for Medicare and Medicaid Services (CMS) began to deficit-fund healthcare expenditures.

As the new millennium unfolded, robust fee-for-service payments propelled hospital revenues and profitability upward. Increasing cash flow expanded providers' capital capacity and fueled massive investment in new acute care facilities to meet pent-up demand. Low interest rates and synthetic debt instruments turbocharged borrowing and capital investment. Happy days were there again.

In 2009, Congress passed the Health Information Technology for Economic and Clinical Health (HITECH) Act that included funding for electronic health records (EHRs). Since 2011, the federal government has invested almost $40 billion in EHRs for doctors and hospitals. Prior to HITECH, over 90% of hospitals primarily used paper health records. Today, fewer than 5% do.

The passage of the Affordable Care Act (ACA) in 2010 was another watershed event. The ACA expanded access to healthcare services and pumped billions of dollars in new revenue into the U.S. healthcare system but failed to control healthcare spending.

It has been a great 20-year run for the healthcare industry. Healthcare expenditures as a percentage of GDP have grown from 13% in 1999 to 18% today. They show no signs of slowing. CMS projects that national healthcare expenditures will increase 5.5% annually through 2027, growing from $3.8 trillion in 2019 to almost $6 trillion by 2027.

Frustration with the industry's inability to control costs, however, is mounting. Government deficits are at record levels driven increasingly by uncontrolled healthcare expenditure. Commercial insurance premiums have grown at a rate three times greater than the consumer price index (CPI) since 1999. The financial fallout from medical bills, including lost wages, is the leading cause of personal bankruptcies.

Hospitals and doctors consume the majority of healthcare spending. Therefore, it should come as no surprise that the American society is demanding greater value from providers. They are manifesting this desire through a powerful blend of market-driven and regulatory reforms.

Business as usual for hospitals and health systems is no longer a viable option.

Revolutionary Forces Driving Margin Pressure

Healthcare's good times cannot last forever. Similar to what happened in the 1990s, healthcare companies are consolidating and

repositioning in response to market and regulatory forces. Large health systems emerged in the late 1990s to strengthen their negotiating leverage with payers and achieve economies of scale.

Initially, most health systems were horizontally integrated hospital holding companies. As they mature, health systems are striving to become vertically integrated operating companies that can accommodate full-risk contracting. This is very much a work in progress. It represents a strategic response to marketplace demands for greater transparency, better outcomes and value-based care delivery.

From a macro perspective, the industry needs to rationalize and/or repurpose the glut of acute care facilities that have materialized over the last two decades. Overinvestment in acute and specialty care services has driven healthcare payments into the stratosphere and minimized the role primary care plays in disease prevention, overall health promotion and care management.

Both the marketplace and government regulators see opportunity to improve the efficiency and effectiveness of healthcare delivery through targeted initiatives. They're making their presence felt. Surveying the competitive landscape, health system leaders are confronting the following forces that are reshaping market demand for healthcare services and rendering many of health system's once-profitable business practices as noncompetitive.

Shifting Payor Mix: Ten thousand baby boomers are aging into Medicare every day. Most are shifting out of higher-paying commercial health insurance into lower-paying government-funded programs. Moreover, new Medicare beneficiaries are rapidly enrolling in Medicare Advantage (MA) plans that force providers to take on more risk than traditional Medicare. Shifting payor dynamics will reduce both revenues per case and impact patient utilization of hospital services as Medicare coverage spreads and MA plans manage utilization.

More Disciplined Purchasing: Corporate buyers are becoming more sophisticated and disciplined buyers of healthcare services. Some,

like Walmart and Comcast, have reconfigured the HMO gatekeeper model through third-party partnerships (e.g., Grand Rounds for Walmart and Crossover Health for Comcast) to manage their employees' primary care and referral needs. Since self-insured corporations bear their employees' healthcare costs and want healthier, more productive employees, their gatekeeper initiatives focus on health promotion, early diagnosis and active care management, opposed to care denials.

Other corporate and governmental buyers are using full risk bundled contracts with preselected providers to improve outcomes and reduce costs. These more disciplined buying practices require all healthcare providers to be more transparent and accountable for their pricing, outcomes and customer experience.

Changing Consumer Behaviors: The CDC now estimates that 47% of Americans with private health insurance are now enrolled in high deductible health plans (HDHP) with an average family deductible of approximately $5,000. These consumers are becoming more cost conscious when evaluating their care options, especially when offered reference prices. Since most HDHP enrollees don't meet their annual deductible, many choose to negotiate cash prices for procedures with providers when they require elective procedures.

Moreover, new technologies and apps are emerging to support consumers who want to shop for healthcare services. With more skin in the game and better tools, increasing numbers of consumers are exercising control over their healthcare purchasing. Like consumers in other industries, healthcare consumers are very price conscious. When it's their money, they won't pay extra for routine care.

New Competitors: Most healthcare services are routine and vulnerable to commodity pricing. Record levels of venture and private equity funding are flowing into healthcare to build companies that offer routine care services at much lower price points. These companies target the inefficient components of the massive healthcare ecosystem and

develop business models that offer high value to purchasers of those services.

New-age healthcare companies are technology savvy, asset light and consumer oriented. They deliver targeted services from urgent care to MRIs to colonoscopies to women's health services, conveniently and with transparent pricing. Market by market, procedure by procedure, diagnostic test by diagnostic test, these companies are increasing margin pressure on traditional providers by offering kinder, smarter, more affordable and more convenient healthcare services.

Dramatically Shifting Regulatory Environment: As an industry, healthcare has influenced the design of regulatory and legislative policies and practices by lobbying elected officials and government agencies. This is becoming harder to do. Current HHS leadership is taking aggressive measures to improve data and price transparency, level competition, and promote value-based purchasing.

On the payment front, CMS is moving towards direct contracting and payment programs that incentivize providers to accept downside frisk for the care they provide. New regulatory proposals seek to improve data interoperability and access, make commercial payers and providers reveal their negotiated payment rates for specific procedures and force site-neutral payment for healthcare service — in part by eliminating higher payments to hospital-based providers.

In the aggregate, these pro-market policies and regulations aim to hold providers, particularly hospitals, more accountable for their performance and outcomes.

The cumulative and compounding effect of these five forces places an enormous strain on those health system business models that optimize revenues at the expense of value-based care delivery. Health systems will face "death by a thousand cuts" as the marketplace finds more efficient ways to deliver appropriate, holistic and affordable healthcare services that are convenient, accessible, reliable and evidenced-based.

Providers Respond

In Ernest Hemingway's The Sun Also Rises, war veteran Bill Gorton asks his buddy Mike Campbell how he went bankrupt. Mike responds, "Two ways. Gradually and then suddenly". This is the defining pattern of disruptive change. It builds slowly and then overwhelms incumbents when they no longer have the capacity to respond.

The most important step for health system leaders now is to understand and appreciate the virulence of the forces aligning to revolutionize healthcare service delivery. Given the size and strength of the nation's health systems, it is easy to be overconfident, even complacent, and believe that business as usual is a sustainable strategy.

The time for change is now. Buyers and consumers of healthcare services are demanding both higher value healthcare services and greater access to essential, but low-paying primary care services (e.g., chronic disease management and behavioral health). Accommodating these market preferences will fundamentally reshape the industry's supply-demand relationships and its allocation of resources. Many hospitals will close.

To improve profitability and increase organizational viability, health system leaders must simultaneously run their acute care operations more efficiently while proactively reconfiguring service delivery platforms. They must deliver more convenient, lower-cost services that consumers increasingly demand. It's a tricky balancing act with little room for error and no time to waste. Here are a few strategies with the biggest potential to relieve margin pressure.

Strategic Partnerships: An African proverb observes that "If you want to go faster, go alone. If you want to go farther, go together". Across industries, businesses are reconfiguring themselves to operate seamless Amazon-like platforms that deliver great products and services tailored to customer needs.

No company excels at everything. Strategic partnerships with companies that can deliver vital services under a unified brand are essential to health systems' long-term sustainability. For example, health systems lack the retail expertise to operate profitable and consumer-friendly urgent care centers. Consequently, some health systems are operating urgent care centers with strategic partners (e.g. Hartford HealthCare with GoHealth) that have mastered that business. These types of strategic partnerships can go a long way together.

Reconfigure Routine Care: The majority of healthcare services are episodic, routine and achieve predictable results. They are essentially retail offerings that lend themselves to high volume, low margin delivery platforms that deliver consistent quality and convenience to consumers. Continuing to expect buyers to pay premium prices for routine services is wishful thinking.

The realistic alternative for health systems is to shift routine care to lower cost, more convenient facilities that can be profitable while receiving commodity-like payment for services rendered. Retail businesses are competitive, lean and customer focused. Health systems have little understanding of or experience in operating retail enterprises, so succeeding as retail service providers will be difficult, if not impossible, for most.

Increased Productivity: "Better, faster, cheaper" has never had more applicability in healthcare than it does now. As in other industries, to be competitive health systems must understand costs, eliminate waste and manage supplies. As payment aligns with cost, effectively managing expenses will translate into higher profits. As Ben Franklin observed almost 300 years ago in Poor Richard's Almanac, "A penny saved is twopence clear".

Effective Revenue Management: Channeling Franklin, it is also true that a penny captured is a penny earned. Fee-for-service is not disappearing. Neither are co-pays and deductibles, in fact they are increasing. Risk-based agreements are expanding across many markets. Providers will need to be effective at managing a diverse spectrum of

payment models. Digitizing claims data, hyper automation, consumer digital engagement and predictive analytics are examples of the essential capabilities needed to optimize a diverse and complex revenue mix. Every new dollar realized goes straight to the bottom line.

Each of these practical strategies will contribute to a health system's ability to deliver high-value services at competitive prices. In this sense, these are tactical rather than pathbreaking initiatives. More than innovation, execution will differentiate winners from losers. Health systems that fail to "gradually" transition to customer-centric service platforms will "suddenly" discover that they've lost market relevance.

Conclusion: Waves and Tides

Every sailor knows that waves move independently from tides. Health system leaders must not mistake today's short-term revenue gains as a signal that they've weathered the disruptive storms confronting the industry. The tide is turning on centralized, expensive and fragmented business models that deliver suboptimal outcomes.

The margin pressures health systems confront are real and not going away. Doubling down on existing business practices is a recipe for failure. Embracing practical strategies that deliver optimal outcomes is the only way to relieve the pressure. Unlike the late 1990s, there are no budget surpluses or pent-up pockets of demand available to rescue providers from themselves.

Instead, health systems must radically reconfigure their care delivery offerings to meet customer service demands and price points. Achieving this level of operating proficiency will require robust digital platforms that frame relevant financial and operational data in real time; strategic partnerships that enhance service provision and create value; and user-friendly technologies that enhance outcomes and consumer experience. Consistency, convenience and cost will differentiate market winners and losers.

A new wave of revolutionary upstart and incumbent healthcare companies is riding the disruptive tide. These companies are shifting resources out of acute and specialty care into better care management, behavioral health and health promotion. They're aligning their services with consumers' needs, wants and desires. They'll win by delivering the right care at the right time in the right places at the right prices.

This article was originally published by 4Sight Health.

Margin Pressure, Part II: The Provider's Response & Forward-Looking Crisis Management

By Dave Johnson and Jeff Jones

In our January 2020 commentary, *Unrelenting Margin Pressures: Overcoming Healthcare's Softening Revenues and Rising Expenses*, we identified the following five forces that are coalescing to drive more value into the delivery of healthcare services:

- More disciplined purchasing of healthcare services
- Consumerism
- A deteriorating payor mix
- New competitors
- A tougher, pro-competition regulatory environment

Their collective impact poses an existential threat to many health systems. Consequently, "business-as-usual" is no longer a viable long-term strategy. Strategic partnerships, reconfiguring routine care, increasing productivity and effective revenue management are value-based strategies that enhance competitiveness and ensure long-term market relevance.

Since publishing the *Unrelenting Margin Pressures* commentary, the COVID-19 (also known as SARS-CoV-2, or as simply as 'coronavirus') pandemic has landed on American shores, shut down the American economy, and placed enormous pressure on providers to care for those inflicted with the contagion. Already under margin pressure, the COVID-19 pandemic has wreaked havoc upon health system business models and generated unprecedented operating losses.

This special edition addresses the financial pressures inflicted on health systems by COVID-19 and strategies for minimizing that pressure. More importantly, it will explain how the pandemic crisis is accelerating the movement to value-based business practices. It will further explore how enlightened health systems can simultaneously

managing the short and longer-term strategic and competitive challenges arising from the COVID-19 pandemic.

Bottom Falling Out

The U.S. healthcare system has gone to war against COVID-19. It is building surge capacity, scouring for lifesaving ventilators and personal protective equipment (PPE), doubling-down on disease testing and tracing, recruiting volunteers to fortify frontline staffing in disease hot spots, and reconfiguring patient engagement practices.

Wars have casualties. As health systems have flexed to increase their COVID-19 treatment capacities, they have seen dramatic declines in non-COVID-19 admissions, surgeries, ED visits and revenues. Combined with increased costs for COVID-specific labor and supplies, health systems are experiencing breathtaking financial losses.

State and federal governments understand the problems confronting health systems and are taking steps to address them. They have relaxed regulatory restrictions to enable more flexible, efficient and timely care delivery. They also are funding programs to provide financial relief to providers as the pandemic unfolds in real time.

Notwithstanding the massive efforts to mobilize and fund COVID-19 care, not all providers will survive the pandemic intact. Quorum's bankruptcy filing is a worrisome signal that the pandemic poses systemic challenges for many providers.

Fighting the War

When organizations conduct post-mortems on their crisis management, most conclude that they should have responded more quickly and aggressively to the crisis. Risk aversion, hesitation and lack of vision impede responsiveness and exact an organizational toll.

In tackling the immediate challenges posed by COVID-19, health system leaders cannot ignore the macro forces driving the industry toward value-based delivery. Enlighted leaders will address short-term

challenges, to the extent possible, in ways that contribute to long-term organizational sustainability.

Anticipation and responsiveness matter. The current operating environment for health systems is dynamic, fluid and chaotic. Leaders should expect surprises and anticipate the need to make decisions with imperfect information.

To apply military phraseology, health system leaders need to avoid, whenever possible, being O.B.E. ("overcome by events"). This requires acknowledgement (things can go wrong), imagination (what could go wrong), and scenario planning (how can they go wrong).

During crises, financial and strategic flexibility are vital. Outcomes trump process. Leaders focus on solving "jobs to be done" in real time. Great organizations, when and wherever possible, push decision-making with accountability to frontline staff.

Leaders make decisions with accurate and actionable data. They communicate clearly and openly. Their actions and consistency of purpose build trust among individuals and between teams. Together, the enterprise unites against the common foe (e.g. COVID-19) with a shared vision of success and template for taking action.

In crisis periods, cash is king. Organizational liquidity enhances responsiveness. It creates time and flexibility to adjust tactics to operating realities. Health systems, to the extent possible, must generate enough liquidity to maintain strategic flexibility during this crisis period.

Tactics for expanding liquidity could include cutting non-essential services, reassignment or furloughing of employees, delaying capital expenditures, expanding credit lines, collecting receivables and delaying payables. With adequate liquidity, health systems can withstand near-term declines in revenues, profits and cash-flow. Without it, they become more vulnerable.

Financial and strategic flexibility are inextricably linked. With financial flexibility, organizations can be more open to innovative, even unorthodox solutions. The emergence of virtual care models illustrates the power of a crisis to break down organizational barriers to change.

At Baylor Scott & White Health (BSWH), for example, daily virtual care visits more than quintupled between March 17th and April 8th. During the same time, tradition face-to-face patient visits decreased by more than fifty percent. BSWH's president Pete McCanna describes the process through which the organization managed this remarkable transition to virtual care:

> We had this elastic demand for eVisits, but didn't have enough providers to cover them. At the same time, clinic visits were down. Providers had time on their hands. We quickly trained them on our virtual care platform and more than tripled BSWH's eVisit capacity within 36 hours.

As illustrated by BSWH's virtual care experience, crisis periods often bring out the best in people and organizations. Their efforts to solve the "jobs to be done" not only relieves short-term pressures, they can become a catalyst to organizational transformation.

Winning the Peace

"Never let a crisis go to waste!" is advice former Chicago Mayor Rahm Emanuel offers frequently to leaders. The COVID-19 crisis gives health systems a chance to overcome the organizational inertia that often frustrates progressive reforms. Health systems should begin to position for recovery now even as they battle COVID-19.

A 2009 *Harvard Business Review* article by John Quelch and Katherine Jocz notes that companies often gain market share exiting from recessions. Economic turmoil disrupts the status quo and forces buyers to reevaluate and reprioritize their purchasing decisions. The authors stress that successful companies acquire new customers by

streamlining product and service portfolios, improving affordability and bolstering trust. Dislocation creates opportunity.

Healthcare's competitive landscape was already changing in fundamental ways before COVID-19. In the words of BSW's McCanna, healthcare is moving from "wholesale to retail, from analog to digital, from physical to virtual, and from centralized to decentralized delivery". The COVID-19 pandemic is accelerating those changes.

Enlightened leaders are using the crisis to advance consumerism, digital connectivity, asset-light business models, strategic partnerships, increased productivity and other value-creating strategies. This approach has the dual benefit of solving short-term COVID-19 problems more effectively while improving longer-term organizational competitiveness.

The pandemic also has created opportunities for new entrants to make their mark on healthcare. Minneapolis-based Zipnosis operates the asynchronous telemedicine platform that enabled BSW to scale its virtual care services so quickly and massively. COVID-19 has become a proving ground for early-stage companies like Zipnosis. They're here to stay.

Less burdensome regulations are enabling all providers to staff and operate more efficiently. As these new regulations prove their merit, perhaps they're also here to stay. The crisis gives policymakers the opportunity to reshape healthcare's regulatory landscape in ways that promote level-field competition, data sharing, and innovation. No industry needs this more than healthcare.

As happens in any truly disruptive period, clear winners and losers emerge. Healthcare will experience more consolidation as consumption patterns drive toward value, transparency and personalization. McCanna is already thinking about how BSW will reclaim its lost volume and then increase the organization's marketshare:

> Our "snapback" plan has two elements. The first is to regain the lost volume by offering compelling services to our customers. The second is to

address our cost structure in fundamental ways that improve outcomes and increase value. Expect to see more virtual care, augmented intelligence and rigorous back-office optimization."

Healthcare's Finest Hour

In the years to come, healthcare will remember the spring of 2020 as the time when the industry recaptured its soul. The dedication and courage of frontline caregivers during this pandemic has been awe-inspiring. We will recall and honor their sacrifices. They have rekindled appreciation for healthcare's humanity and healing mission.

We also will recall the supply shortages, the shortcuts, the miscommunication and logistical failures that made their vital work more difficult, dangerous and heartbreaking. In the pandemic's wake, enlightened companies will deliver on commitments to serve doctors, nurses, technicians and aides better. Healthcare systems that do this will win the public's confidence and trust. They will prosper.

In the final analysis, it is healthcare's business practices that must transform. Healthcare's best leaders are embracing forward-looking crisis management during this perilous time to accelerate true patient-centered care even as they battle COVID-19. This will be their finest hour.

This article was originally published by 4Sight Health.

Is Healthcare a Charity, Social Service or Business? Community Hospital Board Members Contemplate Their Role

By Rex Burgdorfer

Board members of independent hospital companies are in the crosshairs. They govern during a time of intense industry and societal change. Situated at the center of a national struggle, they contend with front-page news, and tweets, daily. Directors are challenged not only by major economic and political issues but also by the tremendous volume of day-to-day operational detail involved in running a complex enterprise.

Peter Drucker famously argued that hospitals were the most complicated form of economic organization. Certainly, managing the large number of stakeholders—federal, state, and local governments, insurance companies, physicians, nurses, employees, unions, patients, local news outlets, and more—is a herculean task.

Juniper Advisory's bankers have been fortunate to work with over 225 hospital system boards across the United States over the last 25 years. We have tremendous respect for the volunteers that oversee non-profit hospitals. They work tirelessly to guide the strategic direction of what are almost always the largest employers in town and leading driver of economic activity. A hospital's importance to the vitality of a region cannot be overstated. That outsized impact seems indelibly tied to the decline of the middle class.

Fifty years ago, well-intended community members volunteered for hospital board responsibilities, agreed to meet quarterly, raised philanthropy, and served as a link to the community. The business they oversaw and the governance demands on these volunteers were relatively modest. Local awareness and prestige were high. It was more Rotary Club than high-stakes corporate boardroom drama. These were the golden years of the middle class—manufacturing output,

civic involvement, patriotism, Elks Clubs, bowling leagues, corporate loyalty, pension plans, JFK Democrats, NASA. Bureaucracy that worked.

All of that changed in the past decade. Today, boards regularly meet multiple times per month, sometimes requiring early morning and late evenings on the same or contiguous days. Conferences, Webinars, and weekend teleconferences are common.

Increased work hours alone, though, would not be cause for concern. The trouble we observe is that this ***additional weight impairs boards as they attempt to nimbly navigate change.***

Fiduciaries are often so consumed by a changing business landscape and increased regulatory scrutiny that major strategic issues slip through the cracks. In a recent example, Juniper advised a hospital system that was considering strategic options that included business combinations. The potential partnership involved once-in-a-generation decisions, including tens of millions of dollars of value, hundreds of jobs, and a potential change-in-ownership of the community's most important and valuable asset.

The Juniper team participated in a three-hour board meeting. It was late in the evening, and the directors had worked full days in their professional lives. Information came at them like a firehose—a new IT installation, narrow network insurance contracts entering the market, a changing payor mix, increased pressure from commercial providers, operational challenges resulting from reduced volumes and greater use of outpatient services, competitors vying for market share by building clinics in the market, physician recruiting shortfalls, foundation fundraising activities, ad infinitum. These topics occupied two-and-a-half hours, but could have taken 20 hours.

The process Juniper was managing (consideration of the sale of the company) was afforded less than 25 minutes. With little energy left in the room, it was impossible to establish a tangible direction. The conversation stalled, the process listed sideways, and the hospital

languished for several extra months. This caused material unnecessary stress on the organization and exposed it to a host of unforeseen outside risks.

As the title of this article suggests, non-profit boards also suffer from an identity that is sometimes difficult to discern. Unlike in commercial corporations, directors are not elected by owners. They are self-perpetuating and not accountable to shareholders. Most we have met with are, understandably, unclear on whether they serve the community, patients, employees, physicians, or the corporation. Uniquely, most also take in more than 50% of their revenue from the government through Medicare and Medicaid.

Universally, hospital boards are populated by extraordinarily well-intended people. They are, however, commonly all local and not necessarily well-versed in the healthcare industry. In the view of many, this stunts innovation and is a leading cause of the industry's inefficiency. Contrast hospital governance norms with a major corporation. There, shareholders elect the board. Members are geographically diverse, bring ideas from a range of backgrounds, and, importantly, are paid experts. Ironically, corporate boards managing billion-dollar global enterprises are regularly smaller than those of 50-bed community hospitals.

Corporations also tend to use committees to a much larger degree than governments or charities. Director committees rely less on outside consulting assistance for routine decisions. In a public company capital markets transaction (for example, a debt or equity offering, or interest rate swap), there is no intermediary consultant between the issuer and underwriter or investment bank. Use of a consultant in this manner, however, is commonplace when non-profit hospital systems access capital. Why? Leadership of public companies are assumed to be sufficiently experienced and sophisticated to internally handle financing and capital structure issues. The result is that non-profit boards are much more involved, spending time and money on operational matters.

This is not intended to slight hospitals in the least. It does, however, provide one hypothesis for why so many hospitals appear fatigued, overwhelmed, and unable to chart a clear course for the future. As Peter Drucker believed, "Strategy is a commodity, execution is an art." Or as the Royal Bank of Scotland's television commercial championed, "Less talk, more action." A practical, "get things done" approach, however, often requires decision making in a compressed timeframe, something hospitals do not excel at. Perhaps the consulting culture, group-think mentality, and non-professional board populations are partly responsible.

One can easily understand the strategic challenge, though. Efficient markets in sectors like financial services and energy can tolerate failure. Allowing Lehman Brothers or Enron to fail, while economically painful, was not catastrophic. The hospital market is not so fortunate[2]. Effective board leadership and performance in the hospital sector can quite literally be a matter of life or death.

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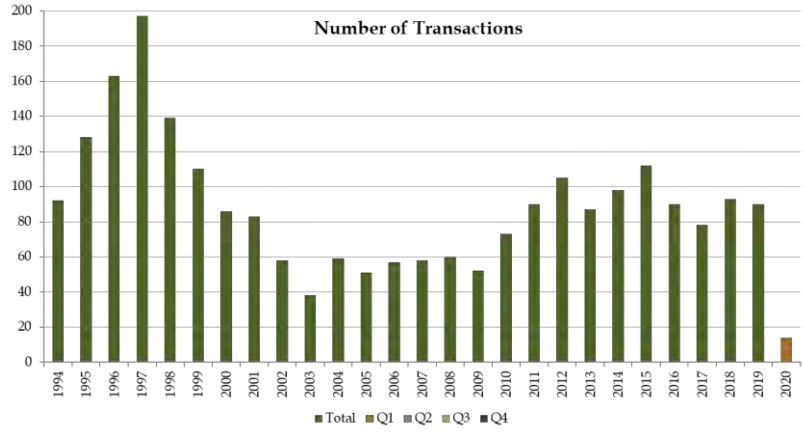
Current Trends in Hospital M&A

By Rex Burgdorfer, Jordan Shields, Barton Walker, Krist Werling and Thomas Brown

Healthcare reform has been a powerful catalyst for consolidation and integration in the hospital industry. We are seeing a significant number of mergers between hospital systems and cases of integration with physicians and other providers.

Consolidation activity has picked up considerably compared with the overall trend for the hospital industry in recent years. In the mid-1990s, the external threat of managed care had prompted a large number of transactions. According to a study by the Bureau of National Affairs, the hospital industry saw a peak in mergers in 1996, with 768 hospital facilities involved in 235 transactions, followed by a decline until 2004, when the growth rate began to gradually rise again. The decline in transactions was dramatic, dropping to between 30 and 50 per year. The transactions that were occurring were largely due to microeconomic issues facing smaller hospitals and some larger systems (usually loss of access to capital and the need to defend against competition).

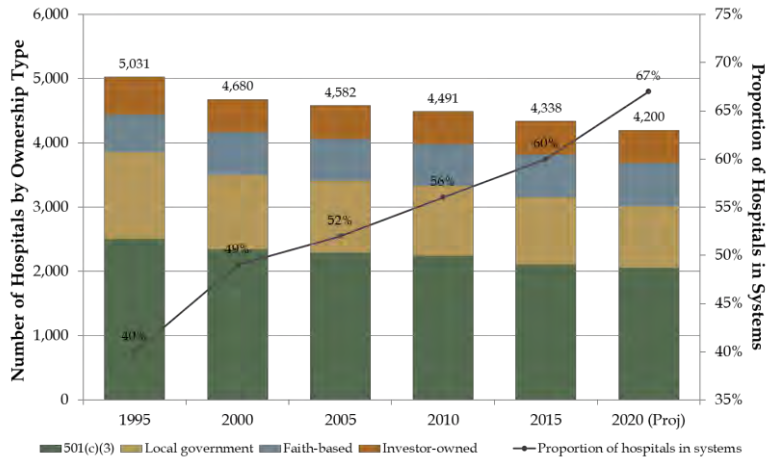
M&A Activity - - increasing transaction volume



According to American Hospital Association data, the overall number of hospitals declined by about 3.5% during the period of 1995 to 2011 from 5,194 hospitals to 5,008 hospitals. At the same time, the number of hospitals affiliated with systems has been increasing: In 1999, only 2,524 of the hospitals in the United States were part of systems, whereas by 2019, that number had increased to over 3,000.

Hospital Industry - - ownership evolution

Today according to the American Hospital Association, approximately 80% of the roughly 4,500 hospitals in the U.S. are operated by not-for-profit organizations and local governments, while for-profit companies operate about 20% of hospitals. For an industry representing 5% of U.S. gross domestic product, the number of independent hospitals represents a staggering amount of fragmentation.



The few companies involved in transactions, which average only between one and two hospitals per transaction, indicate a highly fragmented industry. Among the top ten companies in the hospital industry, each one accounts for only about 1% of the total market, and the largest accounts for only 4% of the market. With 80% of hospitals owned by non-profit organizations, they have less access to capital than is enjoyed by leading companies in other industries. This is because the sole source of external capital for non-profits is the

municipal bond market; contrasted with for-profit companies that can use equity as a means to finance growth. Some industry analysts also blame fragmentation for a portion of the industry's inefficiency. Federal healthcare reform, in part, seeks to bring this industry into the modern era.

Failure to Consolidate

Several reasons are behind the hospital industry's relatively slow rate of consolidation in the past 20 years. A pervasive notion exists that hospitals are part of the local economy and that consumers prefer local oversight and a high level of access to healthcare resources. This notion is underscored by hospitals' desires to remain tax-exempt.

The municipal bond market is, in part, responsible for the hospital industry's fragmentation, but this is changing. As the investor base of municipal securities shifts from retail to institutional holders, issuers will be held to a higher standard and required to float larger offerings. Moreover, when politics rather than business needs drive decision making, local thinking thrives. Thus far, market forces have not been sufficient to force hospitals to consolidate. With the advent of healthcare reform and the decreasing availability of funding through the bond market, the hospital sector is slowly shifting to resemble most other major industries.

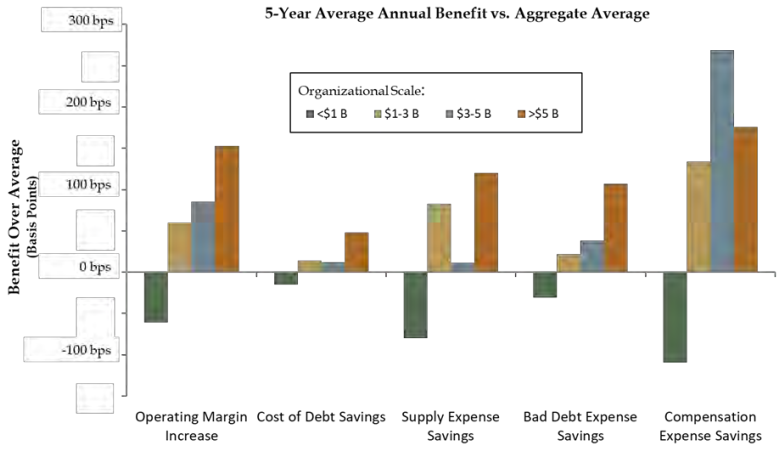
Impact of Healthcare Reform on Consolidation

Healthcare reform will have three key effects on hospital consolidation: decreasing revenues, increasing costs, and directly rewarding or encouraging integration.

Decreasing revenues. Healthcare reform seeks to increase preventative care, keeping patients out of the hospital and thereby decreasing inpatient revenues. Additionally, healthcare reform will decrease payment rates (or at least slow their growth), which will indirectly encourage consolidation by forcing hospitals to find new ways to reduce overhead and increase negotiating clout with suppliers and payors.

The Affordable Care Act includes a value-based purchasing program, which rewards hospitals that exceed quality measures and penalizes underperformers with payment cuts. Many commercial payors are also pursuing this model. The cuts in payments to below-average performers will cross-subsidize the increased payments to above-average performers, ultimately increasing competition and penalizing those that can't keep up. Larger systems or organizations that have greater critical mass will be able to compete more effectively in this environment for several reasons. First, larger systems can spread fixed costs over a broader revenue base and allow higher-performing business units to compensate for those that lag in certain quality measures. Second, they will have easier access to capital and at better rates. Finally, larger systems will be able to more easily develop sophisticated systems that can measure quality – a key ingredient for future success – and share best practices. The following tables illustrate the financial and operating advantage that larger systems wield over their smaller, standalone competitors.

Financial Benefits of Scale



Increasing costs. Healthcare reform is likely to increase the cost of doing business for providers (and particularly hospitals) because compliance costs will significantly increase. For example, each hospital now must publish a list of its standard charges. In addition, every

501(c)(3) hospital must conduct a community health assessment every three years and follow new debt-collection practices. Technology expenditures will increase as both clinical and operational systems are put in place to better manage patient care. As another step to improve clinical quality and manage population health, hospitals will continue to employ more physicians, even as the outlook for physician reimbursement remains bleak. Additionally, the cost of capital for smaller institutions is increasing and directly correlated to size and credit rating.

Encouraging integration. Healthcare reform will directly reward greater clinical integration through the accountable care organization (ACO) model promoted by the Medicare Shared Savings Program and "medical home" or capitated payment models. An ACO allows the sharing of cost savings or the sharing of a set of payments for achieving quality measures, which will directly encourage integration. One particular ACO model would comprise a hospital, primary care physician group, and a specialty physician group. The ACO model requires both shared governance and quality reporting. Hospitals will need a relatively high level of sophistication to develop and manage ACOs. Generally, larger systems and those with more resources are more likely to take advantage of this opportunity.

Current Hospital M&A Market

A new set of buyers and sellers has changed the current merger-and-acquisition market during the past 20 years. Historically, not-for-profit systems were not acquisition-minded, but have now shown interest in expansion during the reform era.

Although not-for-profit systems are sophisticated organizations, they are often inexperienced in merger transactions, which have resulted in some awkward approaches. Sellers also are less motivated by financial desperation than they once were. In the past decade, many hospitals with good market share lost access to capital. Faced with urgent needs to modernize facilities, hospital boards accepted the need to enter into business combination transactions. Today, this is

often not true. Because smaller hospitals and systems are not being forced to merge due to financial considerations, their boards are finding it difficult to agree on potentially transformative transactions.

One clear trend is the increasing difficulty of completing transactions. The incidence of failed mergers—those in which a letter of intent is signed and publicly disclosed, but the transaction does not close—historically did not exceed 5%. In the early 2000s, however, 25% to 50% of letters of intent failed. Although this high percentage of failed transactions might slow the pace of increasing consolidations, it has done nothing to slow the growing interest in consolidation.

Transaction Structures

Current deal structures are different from those of past deals, which were characterized by many conversions and outright sales for cash by not-for-profit to for-profit organizations. Today, discussions about combinations between growth-minded sellers and commercially sophisticated (but merger-market unsophisticated) large consolidators are common. Cashless transactions of one form or another (e.g., membership substitutions or mergers) are common.

Recently, hospitals changed their preferred means of acquisition. Increasingly, they are proactive in acquiring hospitals, even outside their historic markets and across state lines. Both the larger not-for-profits and their targets seem to be more interested in investing in hospitals directly, making capital commitments over a multi-year period and assuming existing debt.

Some not-for-profit systems are making strategic acquisitions that make it harder for investor-owned companies to compete, forcing investor-owned buyers to revise their traditional valuation methodologies to account for premiums paid by large not-for-profit strategic buyers that may not be as financially driven as they are. At the same time, for-profit buyers have been less willing to enter new markets with small positions. In the past a number of established for-profit systems may have shown interest in a 200 bed facility in a new

market, but today they are less likely to seriously consider small- and medium-sized acquisitions in new markets.

Investor-owned companies are also exploring creative models to make their offerings more attractive. For example, in the early 2010s LifePoint received significant attention for its relationship with Duke Medicine. These types of partnerships can be attractive in that they offer the operating and scale efficiencies of a for-profit buyer focused on growing healthcare services at the acquired facility, while simultaneously bringing the clinical and quality infrastructure from the non-profit partner. These innovative models will continue to gain prominence.

Some major cities with large indigent populations are recognizing that from a social perspective they cannot afford to lose hospitals. This perception is driving a new trend in the industry, which is exemplified by two transactions in Massachusetts and Michigan that have been historically hostile to investor-owned buyers. The transactions, which involve the for-profit Vanguard Health Systems in Detroit and Cerberus Capital Management in Boston, illustrate the states' greater acceptance of for-profit companies when these investor-owned systems prevent closure. These transactions represented solutions for hospital systems that, like many banks, have been deemed too big to fail. In Detroit, for example, the state of Michigan approved the sale of the Detroit Medical Center, an eight-hospital not-for-profit health system to Vanguard (now Tenet). In Boston, Caritas Christi Health Care, the state's second largest hospital system, agreed to be purchased by Cerberus, after reportedly unsuccessful attempts to sell to another Catholic-based system.

Community Considerations

When considering a consolidation or sale, a hospital's management and board of directors should consider the community and public relations element. Selling a hospital, especially to an out-of-town buyer, is an emotionally charged issue in most communities. There have been several public-relations disasters where communities rightly or

wrongly concluded that their hospital was sold without adequate disclosure or community input. It is important to prepare boards and the community for any change in hospital ownership. Mistakes in the communications process, or worse, transaction execution, are often measured in the tens or hundreds of millions of dollars.

The educational process begins with the board of directors. The board needs to understand all the factors driving consolidation in general and the circumstances pertaining to its hospital in particular. Once the board understands the key issues, the hospital should decide how to communicate with community leaders and other stakeholders, including physicians and employees. Because lawyers and investment bankers are not experts in public relations, hospitals should consider hiring a public relations firm.

A hospital should be open and transparent when starting a search process for an affiliation partner. Of course, the identity of the parties and negotiations should be kept strictly confidential. It is important to have one or two well-respected physicians on the negotiating committee to create a sense of involvement with medical staff, provided they will not gossip about negotiations.

Finally, the board should consider briefing local leaders and politicians about their plans, even if only by phone. Politicians do not like surprise announcements of a hospital merger. Briefing key local leaders in advance of any public announcement can lead to a warmer reception of the deal.

Tax-Exempt Considerations

The charters of many tax-exempt hospitals require that they serve their local communities. There are many ways to ensure the local community benefits from the sale or merger of its hospital, and to further the charitable mission of the hospital.

First, the transaction can leave a local board in place even if it is subject to reserve powers by the acquiring entity. One particularly effective example of this was when HCA took control of the remainder of

HealthOne and maintained a local board with significant fiduciary responsibility. A deal might also require that a certain percentage of future board members reside in the community. Commitment to charity care is an important consideration, and most acquiring entities quickly agree to maintain the hospital's charity care policies or adopt a comparable policy. They also typically agree to retain all employees and medical staff privileges as part of the transaction. This issue is usually important to state attorneys general who may be required to review the transactions. Affiliation agreements often contain commitments to maintain certain core services and to invest capital or add new services within a certain time. However, such commitments can sometimes be changed if the resulting local advisory board of the seller agrees that changes are warranted.

One way to solidify a new organization is to ensure an entity remains in place that can enforce the agreement against the acquiring entity. Maintaining a local foundation that will not be folded into the new organization can achieve this goal. The local foundation board might be contractually authorized to enforce the agreement. Alternatively, the hospital could designate an individual or organization, such as a community foundation, to ensure the commitments are fulfilled. If, at some future date, the hospital is sold to a for-profit corporation, the local board could be given the authority to seek an alternative deal with a for-profit or not-for-profit organization of its choosing on similar financial terms if it so desired.

Consideration in these transactions typically comes from the sum of (1) purchase price, (2) assumption of liabilities (e.g., long-term debt, pension liabilities, interest rate swaps), and (3) a legally binding commitment to make capital expenditures. Historically, not-for-profit boards negotiated for one, two, or all three essential elements of consideration. The new set of consolidators (the newly acquisitive, large, regionally-prestigious not-for-profits) and the new sellers (strategy-minded, small not-for-profit hospitals) have struggled with transactions where the buyer accrues most of the benefit, with only incidental benefits to the community. In the absence of corporate (SEC)

standards and consequences of the TransUnion case, there is distressingly little attention given to the notion of "fair market value" in the non-profit hospital M&A market.

The heart of the issue is the fiduciary duty of the board to the hospital and the community to further the hospital's charitable purposes. The key issue is whether the hospital receives fair market value for ceding ownership and control of the organization. Boards should understand the strategic alternatives and assess them simultaneously, not sequentially. Tactically, this approach can be difficult, but it best fulfills the board's fiduciary obligations.

Due Diligence

In a merger or acquisition of a heavily regulated business, such as a hospital, the purchaser can inherit serious regulatory liabilities. Because purchasers typically do not like problems, a potential seller should try to fix problems that would deter buyers. By taking a proactive approach, a seller can alleviate the problems that arise in a deal.

The most significant issue is making sure that the hospital's survey history and results (e.g., accreditation, Medicare, and environmental surveys) are in order. If the hospital's record is not completely clean, it should adequately address all issues or deficiencies. The hospital also should have in place a robust compliance plan, in which it regularly monitors physician compensation and financial relationships, to address purchasers' likely concerns about fraud and abuse issues.

Billing and payment issues also should be reviewed. In any transaction where the target is paid by a governmental program, a billing and coding audit is recommended. Certain problems can be detected by examining payment and coding rules. An audit will eliminate any billing and coding compliance shortcomings.

Conclusion

Federal healthcare reform is spurring consolidation in the hospital industry, bringing the promise of substantial change to an industry that

has changed little over the past 20 years and remains highly fragmented compared with other industries. What was recently a cottage industry is rapidly advancing into the modern era. How hospital leaders, boards, and the communities served by their organizations react to this consolidation will determine the shape of the industry in future decades. It will therefore require their great diligence in addressing the many important considerations that consolidation raises. In the same way, senior finance leaders (both internal and external) will need to be cognizant of these trends in order to be prepared with a plan of action when presented with a possible affiliation, merger or consolidation transaction. In many cases, the economics will drive the overall deal's success or failure. Senior finance professionals should pay particular attention to the true extent of hospital liabilities. These include bond issuances, pension liabilities (which may fluctuate dramatically based on market performance and rates), capital leases and other debt. Accurate knowledge of the true amount of these liabilities is crucial to being able to evaluate the sufficiency of any potential combination offers. Finance chiefs will continue to play a lead role in advising their Boards on the ultimate decision of whether to proceed with a transaction.

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Editors' Note: This article was first published in November 2019 before COVID-19 brought on a global recession. It remains relevant today as organizations assess their positions and grapple with the fallout.

Are Hospitals Ready for a Recession?

By Alexandra Normington

News coverage of a possible economic recession flared late in the summer of 2019 with a US Treasury yield curve inversion, a bond market phenomenon that is historically associated with a financial downturn. The inversion came with a 3% drop in the Dow and S&P 500 indices. Healthcare-related stocks took an even larger fall. The Federal Reserve's interest rate cut failed to immediately bolster the market.

While economists cannot precisely pinpoint the start of the next recession, this market volatility should serve as a wake-up call to vulnerable healthcare organizations. As we saw during the Great Recession (Dec. 2007 - June 2009), an economic downturn can be particularly harmful to standalone and government hospitals and health systems currently eking out the slimmest of margins. Hospitals should be preparing now to absorb the financial impact of a recession.

The hospital business is highly subject to consumer utilization patterns. Out-of-pocket healthcare costs continue to be burdensome for many Americans with the proliferation of high-deductible health plans. Half of adults surveyed by the Kaiser Family Foundation in March 2019 said they have put off seeking medical care in the past year due to costs. This comes despite the U.S. currently experiencing one of the greatest periods of economic expansion in its history.

Increases in un- and under-employment and financial insecurity caused by a recession will only further cost avoidance by consumers, as we saw a decade ago. Elective procedures sought by insured patients are generally a hospital's best revenue-generator. During the

Great Recession, scheduled inpatient hospital stays by commercially insured patients dropped 4.5% year-over-year due to coverage loss and patients with coverage seeking care at reduced rates. This resulted in a $3.7 million loss in patient revenue for the average 300-bed hospital. Patients who do seek hospital care during a recession are more likely be sicker and lack meaningful insurance. Overall, the average hospital margin fell from 6.0% in 2007 to 1.8% in 2008, the first full year of the recession, according to a study published in Health Affairs by Bazzoli et. al.

Hospitals and health systems should also brace for a significant hit to their non-operating income. A significant source of income for many hospitals comes from their investment portfolios. A recent analysis by Juniper found that many hospitals' balance sheets were bolstered by a strong stock market in 2017 and the first three quarters of 2018. Average investment income revenue represented 47.0% of net margin for 90 sampled independent hospitals across the country. The average operating margin for these hospitals was -0.8% and average net income margin was 3.7%: the positive uptick almost entirely thanks to investment revenues.

The stock market dive in the 4th quarter of 2018 gave us a preview of a recessionary experience. Most institutions experienced notable investment income losses in that time period. (A dozen of the largest non-profit systems in the U.S. ended the year with a collective $3.7bn loss on investments.) The hurt brought on by a full recession would be prolonged. Between 1945 and 2001, the average recession was about three and a half quarters. The Great Recession stretched on for six quarters. The impact of an extended downturn on investment income would prove devastating for many hospitals and health systems.

Hospitals that receive meaningful philanthropic or governmental support will also likely see such revenues decline. Charitable giving dropped 7.0% in 2008 and another 6.2% in 2009, the height of the Great Recession, and remained "well below the 2007 level" in

subsequent years, according to the Stanford Center on Poverty and Inequality. Cash-strapped local governmental entities may be less inclined to support public-sector hospital losses, while hospitals that enjoy direct tax revenues could see those funds decline significantly.

Unsurprisingly, the Bazzoli study noted that, "operating margins for hospitals with mixed or weak initial performance generally declined throughout [the Great Recession]". The study authors also found that hospitals in systems fared better than their independent peers, theorizing that "systems may provide resources that buffer individual hospitals against local economic downturns".

While hospitals and health systems were historically considered to be robust performers in a weak economy, they are not recession-proof. The financial strain of a recession can negatively impact a hospital's ability to achieve optimal patient outcomes, maintain financial viability, and make necessary investments for the future.

Hospitals must develop strategies to cope in an environment with fewer adequately insured inpatients, increased self-pay, and limited non-operating revenues. Examining cost reductions is important, but likely insufficient to fully insulate an organization from a multi-year downturn. Comprehensive outpatient initiatives, service line enhancements and exploration of strategic, scale-focused partnerships should all be on the table. With forethought and planning at the Board and executive level, a hospital or system can position itself to remain a sustainable community anchor and preserve access to quality health care services in times of economic stress.

This article was originally published by Juniper Advisory.

Community Considerations for Hospital Transactions

By Barton Walker, Krist Werling, Rex Burgdorfer and Jordan Shields

When evaluating change-of-control transactions, hospital boards need to be cognizant not only of their fiduciary duties to the corporation, but also of how their decisions will impact the broader community. If not handled correctly, public concerns can gain momentum and derail transactions that boards have specifically structured to meet the long-term healthcare needs of their communities. There have been repeated public relations disasters in which communities rightly or wrongly concluded that their hospital was sold out from under them without adequate disclosure or community input. To ensure a successful outcome, it's important to design a transaction process that anticipates community concerns and addresses them proactively and transparently.

This article suggests a number of strategies to ensure that community concerns are appropriately addressed in the design and implementation of a process, before they put transactions at risk. Within the context of the board's fiduciary duties, we will review the role of community leaders (including the often conflicting objectives of boards, management, staff, local government, physicians, and business leaders), securing investments in the community, the provision of charity care, and local control. A well-considered anticipatory public relations strategy can defuse many of these issues before they gain momentum.

Conducting a thorough, exhaustive, and open process with the assistance of a public relations firm is one of the key elements of securing regulatory approval for the transaction. Ultimately, this supports the board's goal of ensuring the long-term provision of quality healthcare for its community.

Balancing the Concerns of Community Leaders

As our national economy continues to migrate from manufacturing to services, so too does the role that hospitals play within the economy. Thirty years ago community members typically saw hospitals solely as places of healing and would not have characterized them also as economic engines powering regional growth. Today, hospitals are often the largest employers in town. They can also attract independent physicians who support the local tax base and local businesses. Hospitals often have large contracts with local service providers (e.g., laundry, construction, food services, etc.), as well. Given hospitals' important role in their local economies, the list of community leaders that have a stake in their success and stability is long.

This was demonstrated during the COVID-19 outbreak. As the broad economy ground to a halt, healthcare workers stayed on the job. In fact, many communities put out calls for professionals who had left the industry to return, waiving licensing requirements for nurses, physicians and other professionals who had left the field but were willing and able to answer the call of duty. At the same time that hospitals kept large swaths of the workforce in place, the organizations themselves faced massive losses. As elective procedures and visits were canceled and delayed, these high fixed costs businesses faced crashing revenues with very limited ability to slow expenses.

With a diverse set of stakeholders, all with their own vested interests, the risk of an organized campaign opposing a change in ownership is high. Unfortunately, while resistance is often couched in words of concern about community control, access to care, and services for the indigent, what is quite often at play is concern over how a transaction might impact that individual's personal or business interests. It is the board's responsibility to keep the discussion on track and to ensure that it continues to serve the interests of its organization and long-term access to quality care for the community (or in the case of impending bankruptcy to also secure the interests of the creditors). In the face of community resistance, the board should clearly communicate its objectives in exploring a transaction and work with its advisors to directly address community concerns. When those concerns

are legitimate, they can almost invariably be addressed through the transaction's legal structure, financial arrangements, or included in the contractual language with the selected partner.

Securing Investments in the Community

The overarching goal of nearly all hospital transactions is to support and secure the long-term provision of quality healthcare for the community. The form that this support takes, however, can vary widely, and a given transaction can include a number of different forms of economic and noneconomic consideration.

Types of economic consideration can include:

- Cash payment to the seller or existing related foundation
- Commitment that the buyer will assume long-term debt and other liabilities (e.g., pension obligations, out-of-the-money interest rate swaps, etc.)
- Capital commitments by the buyer to fund strategic projects (e.g., building construction, major equipment, specific new programmatic offerings)
- Agreements from the buyer to continue the same charity care policies in place at the time of closing
- Cash that the seller leaves behind or transfers to a foundation at the time the transaction closes

The financial proceeds created from the transaction are often placed into a locally controlled grant-making foundation that continues to support healthcare in the community. The types of non-economic consideration are even more diverse and include organizational resources to recruit and retain physicians (e.g., connections to residency programs, recruiting infrastructure, etc.), agreement by the buyer to meet quality or patient satisfaction targets, or agreement by the buyer to retain all the employees with comparable or improved salaries and benefits. If something can be measured it can be built into the contract.

These diverse forms of economic and noneconomic consideration give boards a unique opportunity through the transaction process to

identify what is most important to them (e.g., net proceeds, physician network, reputation, quality, patient satisfaction, etc.) and then to work with their advisors to maximize those outcomes through a competitive transaction process.

Change of Control and Charity Care

Commitment to charity care is an important consideration and one that is often of primary concern to local leaders. This issue is also usually very important to state attorneys general and other regulators who may review the transaction. It is worth noting that much of the research into the continued provision of care to the indigent after hospital conversions has found little to no impact. The article "A Statistical Analysis of the Impact of Non-profit Hospital Conversions on Hospitals and Communities," published by The Commonwealth Fund, examined the impact of non-profit to for-profit conversions on several measures of hospital community benefits, including care to the indigent, and found no impact on charity care caused by conversion. The Economic & Social Research Institute's report for the Kaiser Family Foundation titled "The Privatization of Public Hospitals" had consistent findings that hospital conversions do not lead to reductions in charity care. In practice, most acquiring entities (regardless of tax status) will agree to maintain the hospital's charity care policies or at least adopt a comparable policy without resistance.

Addressing Concerns about Local Control

Hospital boards have a tendency to identify "local control" as an issue of primary importance when considering business combinations. When arguing the merits of local control, board members often cite the uniqueness of their communities and the need for their continued oversight in ensuring that services are not reduced. Focusing on local control, however, misses the point.

Local control is not the same thing as securing the long-term provision of quality healthcare for the community. In fact, it can be the opposite. For example, boards and management teams routinely continue to support services at their hospitals despite recurring problems

with low quality, high cost, or volumes below the minimum thresholds considered necessary for the safe provision of care. It is the rare board that proactively closes its open-heart program due to safety concerns from a lack of volume (e.g., fewer than 100 open heart surgeries). By confusing local control with the long-term provision of quality healthcare in the community, boards can miss opportunities to partner with strong operators that have the financial resources to invest capital, the organizational breadth to recruit and retain the highest quality practitioners, and the management resources to identify and disseminate best practices.

Another factor that is often included in the shorthand of "local control" is concern about the breadth of services that the acquiror will continue to provide. Hospital change-in-control contracts almost invariably include a commitment by the acquiring organization to maintain and/or expand services at the hospital that is selling for a given period of time. While these terms are difficult to enforce through the courts, they are rarely violated. This is because buyers have a significant reputational risk any time they fail to live up to the promises made in the definitive agreement. Acquirors need to maintain their reputations as vigilant operators if they hope to be able to grow their companies and acquire additional hospitals in the future.

Communicating the Board's Fiduciary Duties

Regardless of the type of transaction, state attorneys general always ask two questions of hospital boards:
1) Why is the board considering a change of control?
2) Why did the board select this particular suitor and structure?

The first question depends on whether the board conducted a thorough, fact-based, and well documented assessment of alternatives. The answer to the second question must invariably be that the board approached a broad market of buyers, arrived at a fair market value, and selected the suitor and structure for clear reasons that satisfy the board's fiduciary obligations to the hospital organization and, if applicable, the community at large.

At the core of the board's responsibilities in this context are the fiduciary duties imposed by state law. In general, a board of directors will have a duty of loyalty and a duty of care with respect to their conduct and decision making on behalf of the organization. These specific duties can vary from state to state, but some common principles emerge almost universally.

The duty of loyalty most commonly relates to conflicts of interest. In other words, is the board acting in the organization's best interests, or is the board acting in furtherance of some other personal or profit-seeking motive? For example, does a particular director stand to benefit personally from the transaction? Unlike a for-profit corporation, the board's job in this context is not to maximize profitability or a return for shareholders. In most 501(c)(3) organizations, the primary goal must be serving charitable purposes.

The duty of care is more generally focused on process and requires the board to gather all of the relevant information before making a decision. The amount of due diligence that is required can vary, depending on the circumstances. In all cases, the board should ensure that it has engaged in a full investigation of the relevant details. In the context of a hospital sale, the duty of care would usually require the board to consider other alternatives, to justify the ultimate purchase price in light of fair market value, and to evaluate any competing offers.

In addition to ensuring that the board is satisfying its fiduciary duties, it is important that the board explicitly communicate this to the public. This reassures the members of the community that the board is working in their best interests.

Breach of a fiduciary duty is a serious matter for the organization and can also result in individual liability for the breaching director. The risk of breach is heightened when boards or management teams pursue a change of control with what they believe to be the "right" partner without exploring other options. This can result in the board failing to realize significant economic (often in the hundreds of millions of dollars) and non-economic consideration for its organization and

failing to maximize the value of what is inherently a community asset.

Conclusion

Because of the role that hospitals play in their local communities, change-of-control transactions are once-in-a-generation, highly emotional, stress-laden events for their directors. This can result in boards being distracted from their responsibility to ensure the best outcome for their organizations. Boards that effectively stay focused on the underlying organizational realities of the transaction maximize value for their communities.

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Hospital Industry Structure: Considering the Impact of the ACA

By James Burgdorfer

Leading up to enactment of the ACA, health policy experts had concluded that the U.S. healthcare delivery system was consuming too great a share of the economy. Essentially, the industry was viewed to be too expensive for the country and patients and providing mediocre health outcomes. These factors were the economic rationale for healthcare reform and, eventually, implementation of the ACA.

The ACA was viewed to have two primary objectives: control the cost of healthcare and provide improvements to the healthcare system including expanding the number of people with insurance coverage and adding safeguards for patients. The hospital industry believed that the ACA would impact the economics of the industry in two fundamental ways. First, the cost of doing business would increase as the industry moved from fee-for-service to a value-based structure. Second, reimbursement would decline as Medicare rates were reduced.

As a result, it was believed that the ACA might significantly increase consolidation between hospitals and result in the creation of larger systems of care so as to achieve economies of scale. Juniper felt this could result in more transactions, larger transactions, interstate transactions, and more transactions involving non-profit buyers. Further supporting the notion of creating larger companies, evidence suggested that better health outcomes were achieved by larger organizations that were able to devote greater resources to standardizing protocols. Now, more than six years into the ACA, and at the beginning of likely change to it, it is useful to consider the impact of the ACA on the ownership of the industry and its level of concentration.

Impact of the ACA on Hospital Industry Structure

The information on hospitals in the American Hospital Association (AHA) database is focused on facilities. As a result, an understanding of the commercial structure of the industry is accomplished through considering, in sequence, the number and type of hospital facilities, the development of hospital systems and companies, and the size and nature of these companies.

The data on hospital *facilities* provides basic information on the number of individual hospitals and their ownership forms. The information concerning the development of hospital *systems* provides further insight into the overall ownership and control of the industry. The data on hospital *companies*, describes the formation of business entities in the industry and their access to capital and relative size.

Hospital Facilities

Several features of the AHA database necessitated adjustment to fit these goals:

- Certain facilities included in the AHA data categorized as "other" have business characteristics that differ from general acute care hospitals. These include long-term acute care, psychiatric, and Veterans Affairs hospitals. We eliminated these from the data in the charts below so as to focus on the general acute care hospital industry only. We believe this provides a more accurate picture of the hospital business.
- Similarly, the AHA data concerning investor-owned facilities includes long-term acute care, psychiatric, behavioral health, and specialty hospitals. For the same reason, we excluded these from the data.
- The AHA groups academic, local government, and 501(c)(3) systems into one "non-profit" category. We believe the majority of these are 501(c)(3) community hospitals. The majority of local

government-owned systems are single hospitals, and most academic systems, at least at present, are freestanding facilities.

- Religious-sponsored facilities tend to be part of systems. We believe the number of stand-alone religious-sponsored facilities is insignificant.

Table 1 reflects changes in the number of general acute care and critical access hospitals, as reflected by provider numbers, over time and by ownership type. It also indicates the proportion of all hospitals held by each ownership group.

Despite a slight decline in the total number of facilities, there has been no meaningful change in the ownership structure of the hospital industry over the past 25 years. The largest shifts have occurred during periods of externally stimulated consolidation (i.e., in the mid-1990s and during the ACA years). Community 501(c)(3) non-profit hospitals had the largest proportionate decrease between 2008 and 2016 (11%) due to consolidation and closures of very small hospitals.

The number of investor-owned general acute care hospitals increased slightly during the 2008–2016 period, after declining slightly during the 1995–2008 period. However, there are fewer well-capitalized and investor-owned companies in 2016. Also, this sector's participation in M&A transactions is declining.

Table 1: Hospital Facilities

Ownership	1995	2000	2005	2008	2013	2016
501(c)(3) non-profit hospitals[1]	2,507	2,341	2,295	2,265	2,079	2,015
Proportion of total hospitals	50%	50%	50%	50%	47%	47%
Governmental hospitals	1,350	1,163	1,110	1,105	1,068	971
Proportion of total hospitals	27%	25%	24%	24%	24%	22%
Faith-based hospitals	585	662	663	658	667	726
Proportion of total hospitals	12%	14%	15%	15%	15%	17%
Total non-profit hospitals	**4,442**	**4,166**	**4,068**	**4,028**	**3,814**	**3,712**
Proportion of total hospitals	88%	89%	89%	89%	87%	86%
Total investor-owned hospitals	**589**	**514**	**514**	**513**	**574**	**618**
Proportion of total hospitals	12%	11%	11%	11%	13%	14%
Total hospitals[2]	5,031	4,680	4,582	4,541	4,388	4,330

Sources: American Hospital Association, *Modern Healthcare,* Definitive Healthcare, Juniper estimates.
Notes:
1. Includes community 501(c)(3) and academic hospitals.
2. General acute care and critical access hospitals only. Long-term acute care, Veteran Affairs, and other specialty hospitals excluded.

Table 2 describes the source of change in the number of hospital facilities.

The majority of change resulted from M&A transactions. Net hospital closures have not played a significant role in consolidation. However, it is possible that closures could increase somewhat in the foreseeable future as struggling hospitals might have difficulty finding partners. Despite much commentary to the contrary, the number of announced M&A transactions increased only slightly during the 2008–2016 period. The size of transactions, measured by the number of hospitals involved, has also been consistently small over this period, averaging approximately one-and-one-half hospitals per transaction. The only exceptions were during years when the data were impacted by large transactions amongst investor-owned companies.

Table 2: Change in Hospital Facilities

	1995	2000	2005	2008	2013	2016
Total hospitals	5,031	4,680	4,582	4,541	4,388	4,340
M&A market						
Announced transactions	128	86	50	60	100	90
Avg. number of hospitals per transaction	NA	1.5	1.8	1.3	2.5	1.2
Total hospitals involved	**NA**	**132**	**88**	**78**	**247**	**111**

Sources: American Hospital Association, *Modern Healthcare,* Definitive Healthcare, Juniper estimates.

Table 3 reviews the development of multi-hospital systems. These include non-profit and investor-owned general acute care systems.

This is the first data that can be used to assess the overall level of *business concentration* in the industry. The proportion of hospitals that are part of systems is one measure of such concentration. During the 2008–2016 period there was gradual concentration of the hospital industry. The proportion of hospitals that are part of systems increased from 55% in 2008 to 65% in 2016. This increase in concentration has been occurring at a relatively consistent pace over the past 20 years. The business entities, themselves, have not become larger. In fact, as measured by the number of hospital systems, they have become slightly smaller.

Table 3: Hospital System Development

	1995	2000	2005	2008	2013	2016
Total hospitals	5,031	4,680	4,582	4,541	4,388	4,330
Total hospital systems	253	266	314	330	362	386
Hospitals in systems	2,040	2,291	2,387	2,488	2,482	2,825
Hospitals per system	8.1	8.6	7.6	7.5	6.9	7.3
Proportion of hospitals in systems	41%	49%	52%	55%	57%	65%
Independent hospitals—*not* in a system	2,991	2,389	2,195	2,053	1,906	1,505
Proportion of hospitals not in systems	59%	51%	48%	45%	43%	35%

Sources: American Hospital Association, *Modern Healthcare*, Definitive Healthcare, Juniper estimates.

Table 4 describes the development of multi-hospital systems by ownership type.

In continuing to assess the development of multi-hospital systems between 2008 and 2016, we consider which types of non-profit hospitals have been most inclined to consolidate (i.e., by either forming or becoming part of multi-hospital systems). Over this period, the number of community 501(c) (3) systems grew by 15%. The number of Catholic-sponsored systems shrank by 15%, primarily as a result of intra-Catholic mergers. These resulted in fewer, but larger Catholic systems. The number of investor-owned companies remained constant. However, there has been considerable consolidation amongst large publicly held investor-owned companies.

Table 4: Ownership of Hospital Systems

	1995	2000	2005	2008	2013	2016
Non-profit systems						
Community 501(c)(3) and governmental	162	195	244	264	297	324
Faith-based	71	56	55	51	50	47
Catholic	57	45	42	39	35	33
Other	14	11	13	12	15	14
Total non-profit systems	**233**	**251**	**299**	**315**	**347**	**371**
Total investor-owned companies	**20**	**15**	**15**	**15**	**15**	**15**
Total non-profit and investor-owned systems	**253**	**266**	**314**	**330**	**362**	**386**

Sources: American Hospital Association, *Modern Healthcare*, Definitive Healthcare, Juniper estimates.

Tables 5–9 describe the development of multi-hospital systems by *ownership type.*

Table 5 describes the development of community 501(c)(3) systems.

During the 2008–2016 period, the number of multi-hospital systems increased by 23% and the proportion of all acute care hospitals in systems increased to 35%. However, the size of these systems, as measured by number of hospitals, shrank slightly.

Table 5: Community Systems

	1995	2000	2005	2008	2013	2016
Community 501(c)(3) and governmental systems	162	195	244	264	297	324
Hospitals in community systems	866	1,115	1,210	1,317	1,270	1,506
Hospitals per community system	5.3	5.7	5.0	5.0	4.3	4.6
Proportion of all systems that are community systems	64%	73%	78%	80%	82%	84%
Proportion of all hospitals in community systems	17%	24%	26%	29%	29%	35%

Sources: American Hospital Association, *Modern Healthcare*, Definitive Healthcare, Juniper estimates.

Next, we consider the development of Catholic-sponsored systems since 1995 (see Table 6). Non-Catholic faith-based systems are not a significant group from a national point of view.

During the 2008–2016 period, smaller Catholic systems continued to merge into large Catholic systems. The proportion of total systems that are Catholic declined in the 2000s. The proportion of total hospitals that are sponsored by the Catholic Church increased slightly. The size of Catholic systems, as measured by numbers of hospitals, continued to increase. We suspect that this is attributable to a strong sense of ownership and commonality of purpose that is present in Catholic systems.

Table 6: Catholic Systems

	1995	2000	2005	2008	2013	2016
Catholic systems	57	45	42	39	35	33
Hospitals in Catholic systems	488	560	555	556	521	588
Hospitals per Catholic system	8.6	12.4	13.2	14.3	14.9	17.8
Proportion of all systems that are Catholic systems	23%	17%	13%	12%	10%	9%
Proportion of all hospitals in Catholic systems	10%	12%	12%	12%	12%	14%

Sources: American Hospital Association, *Modern Healthcare*, Definitive Healthcare, Juniper estimates.

We summarize the development of *all non-profit systems* in Table 7.

Between 2008 and 2016, the number of all non-profit systems increased by 18%, although the number of hospitals that were part of these systems grew by only 2%. The proportion of all hospitals that are part of a non-profit system increased from 43% to 51%. However, the number of hospitals per system shrank from 6.3 to 5.9.

Table 7: All Non-Profit Systems

	1995	2000	2005	2008	2013	2016
Non-profit systems	233	251	299	315	347	371
Hospitals in non-profit systems	1,451	1,777	1,873	1,975	1,908	2,207
Hospitals per non-profit system	6.2	7.1	6.3	6.3	5.5	5.9
Proportion of all systems that are non-profit	92%	94%	95%	95%	96%	96%
Proportion of all hospitals in non-profit systems	29%	38%	41%	43%	43%	51%

Sources: American Hospital Association, *Modern Healthcare*, Definitive Healthcare, Juniper estimates.

Table 8 reviews the development of *investor-owned systems*.

The investor-owned sector has not been growing. Investor-owned companies are, however, much larger, measured by number of hospitals, than any of the non-profit system groupings. The investor-owned companies average 40.3 hospitals per system versus 5.9 hospitals per system for all non-profits. Again, one would attribute this to board decisions that reflect the fact that ownership nominates board members of investor-owned companies.

Table 8: Investor-Owned Companies

	1995	2000	2005	2008	2013	2016
Investor-owned companies	20	15	15	15	15	15
Hospitals in investor-owned companies	589	514	514	513	574	605
Hospitals per investor-owned company	29.5	34.3	34.3	34.2	38.3	40.3
Proportion of all systems that are investor-owned companies	8%	6%	5%	5%	4%	4%
Proportion of hospitals in investor-owned companies	12%	11%	11%	11%	13%	14%

Sources: American Hospital Association, *Modern Healthcare*, Definitive Healthcare, Juniper estimates.

Table 9 reviews the development of *all systems*, both non-profit and investor-owned.

The total number of hospital systems and their proportion of all hospitals has increased since the late 1995. However, the number of hospitals per system is stagnant, indicating that hospital systems, on average, remain relatively small businesses.

Table 9: All Systems Combined

	1995	2000	2005	2008	2013	2016
Hospital systems	253	266	314	330	362	386
Hospitals in systems	2,040	2,291	2,387	2,488	2,482	2,825
Hospitals per system	8.1	8.6	7.6	7.5	6.9	7.3
Proportion of all hospitals in systems	41%	49%	52%	55%	57%	65%

Sources: American Hospital Association, *Modern Healthcare*, Definitive Healthcare, Juniper estimates.

Hospital Companies

In order to better understand the extent to which control has become more centralized, we next consider changes to the number of business entities or *companies* in the hospital industry (see Table 10). By combining the number of independent hospitals with the total number of systems, we approximate the number of businesses (i.e., entities under discrete ownership and governance control). Between 2008 and 2016, the number of companies continued to decline through consolidation; however, there are still nearly 1,900 companies with distinct boards of directors and managements making up the general acute care industry.

Table 10: Hospital Companies

	1995	2000	2005	2008	2013	2016
Hospital systems	253	266	314	330	362	386
Independent hospitals	2,991	2,389	2,195	2,053	1,906	1,505
Total hospital *companies*	3,244	2,655	2,509	2,383	2,268	1,891

Sources: American Hospital Association, *Modern Healthcare*, Definitive Healthcare, Juniper estimates.

Table 11 lists the 10 largest hospital companies by size, as measured by revenues, and market share. Consolidation has caused the share of market occupied by the 10 largest companies to increase from 15% in 2008 to 18% in 2015.

Table 11: Largest Hospital Systems—2015

10 Largest Hospital Systems	Total Revenues in Billions	Market Share	Tax Status	Debt Rating
HCA	$39.7	4.0%	IO	Ba2
Ascension Health	$20.5	2.1%	NP	Aa2
Community Health Systems	$19.4	2.0%	IO	B2
Tenet Healthcare	$18.6	1.9%	IO	B2
Catholic Health Initiatives	$15.0	1.5%	NP	Baa1
Trinity Health	$14.7	1.5%	NP	Aa2
Providence Health	$14.4	1.4%	NP	Aa3
UPMC	$12.8	1.3%	NP	Aa3
Dignity Health	$12.6	1.3%	NP	A2
Sutter Health	$11.0	1.1%	NP	Aa3
Total, 10 Largest Hospital Systems	**$178.7**	**18.0%**	-	-
Hospital industry, aggregate	$994.0			

Sources: Company Web sites, audited financial statements, credit rating agencies, Juniper estimates.
IO = investor-owned, NP = non-profit

The hospital industry has one market leader, in terms of size, which commands only 4% of industry revenue. By comparison, the leaders in the airline and banking industries occupy 22% and 23% of their industries, respectively. Frequently, more than half of the top 10 competitors in any given industry are of relatively comparable size. However, Ascension, HCA's largest competitor, is only one-half the size of HCA in terms of revenues. Historically, such comparisons have been viewed to be less important in the hospital industry due to local and regional, rather than national market characteristics, and lack of international markets.

Market leaders of most major industries have access to capital, which is significantly better than that experienced by even the leading hospital companies. In every mature major industry except the hospital industry, the leading companies have access to both equity and debt markets. Access to debt is characterized by strong investment grade ratings and the ability to issue debt in most of the major global markets and, also, be able to issue commercial paper and medium-term notes.

There are no hospital companies, non-profit or investor-owned, with this sort of access to capital. Approximately 40% of non-profits have strong credit ratings and good access to debt, although limited to

municipal bond, private institutional, and bank markets. None, of course, have access to equity. Currently, *no* investor-owned companies have investment-grade ratings, and only five are publicly held.

Observations

As noted in our 2010 review, there was only modest change in the ownership and concentration of the hospital industry from 1995 to 2008. This article describes the impact of the first six years of the ACA, through 2016, on consolidation. Some notable findings include:

- Despite references to enormous levels of merger activity among hospitals, the pace of announced combinations was only moderate during the entire period, and well below levels experienced in the mid-1990s.
- However, there has been an increase in the systemization of hospitals. More hospitals are now part of multi-hospital systems (65% in 2016, versus 55% in 2008). The size of these systems has not increased since 2008 and, on average, they remain small businesses.
- An increasing proportion of hospital M&A transactions feature non-profit buyers. As a result, there have been more mergers and fewer asset acquisitions during the first years of the ACA.
- Only Catholic-sponsored and investor-owned hospital systems have combined into significantly larger companies. We believe this is due to the presence of, and accountability to, "owners" for these two groups.
- There have been no large interstate combinations between non-profit systems.
- Academic hospitals are beginning to expand by acquiring non-profit hospitals in their region.
- Despite some consolidation, there remain nearly 1,900 separate business entities, and the largest companies are small compared to their peers in other industries.

- The nature and tone of the merger market has been impacted as hospital companies struggle with the implications of healthcare reform and the ACA:
- Increasingly, boards of hospitals are considering independence. Approximately 80% of independent hospitals and small systems were doing this in 2016, up from 15% in 2008. As a result, it has become much more acceptable for boards to acknowledge, often publicly, that they are considering the topic.
- There has been a very significant increase in the number of affiliations and alliances. These are contractual arrangements in which no ownership or control is exchanged. They have been occurring at the rate of several hundred per year recently.
- The significant growth in acquisitiveness by larger non-profits has resulted in many new participants in merger transactions.
- Transactions are taking considerably more time to complete and are more fragile.
- Mergers involving government-owned hospitals have been burdened with political disputes. As a result, this sector of the industry is changing very slowly.
- We sense that there is a bias towards combining through pre-packaged bankruptcies as hospitals approach the "zone of insolvency."
- The health insurance industry has continued to consolidate. Fewer than 10 companies comprise the majority of the health insurance market.

The ACA had two primary objectives: lowering the cost of healthcare and improving coverage and protection. Little progress has been made on the first objective; the cost of healthcare continues to consume more than 16% of GDP.

The ACA has made significant progress on the second objective as 20 million additional people have health insurance coverage and

improved protections are in place. Regardless of what happens to the ACA itself, the industry continues to move towards value-based care and reimbursement. As a result, new ways and structures will need to be found that will enable it to deliver care more efficiently.

The negative impact of the industry's fragmented structure on efficiency and effectiveness has been well-documented. Other major industries with characteristics similar to the hospital industry (i.e., commercial complexity, capital intensity, and heavy regulation) have fewer and larger companies. Only a few urban markets (e.g., Cleveland, Denver, and Dallas) benefit from strong larger companies. Many continue to ask why the industry remains so fragmented.

The hospital industry, uniquely, has evolved from a complex and interrelated set of mission and commercial objectives, but the determinants of success have changed enormously. In the past, the hospital industry's local approach and fragmented structure fitted the needs of the market and were consistent with its transportation, commercial, and reimbursement characteristics. This evolution along with the governance structure of the community non-profit hospital industry plays a large role in its resistance to structural change. In our view, the conflict between the exigencies of reform versus the governance preference for independence is the largest factor facing the industry today.

In addition, the lack of structural change over the past decade was partially the result of strict antitrust enforcement by the FTC, and strong demand from the municipal bond market. Ten years ago, many observers thought that the municipal bond market would be less willing to buy small issues of small hospital companies. Surprisingly, this was not the case. Also, historically low interest rates during the period enabled many hospital companies to remain independent. Given all of the factors described above, it is hard to predicate the future pace of consolidation. We believe it is likely that business combinations will continue at a moderate level and that they will likely continue to be hard to complete. Should any of several things happen,

however, the potential for *disruption* of the industry exists. First, significant change in the capital markets could cause an increase in consolidation. This would most likely be in the form of dramatically higher interest rates or a substantial decrease in demand from the municipal market due to changes in income tax policy. Also, potential repeal-and-postpone scenarios could cause significant economic stress on hospital financial performance with the same result. Should insurance companies be granted the ability to sell policies across state lines, large community non-profits might actively consider interstate business combinations. This sort of growth might be less likely to meet with FTC resistance than has been the case with mergers in contiguous markets.

We are optimistic that the industry will encourage innovative thinking and pave the way for the strong organizations that can provide healthcare in new and unique ways, regardless of ownership, location, size, or other factors addressed in this article. We hope this updated review is of help to industry participants as they consider industry trends, strategic responses, and market positions in order to reach the best conclusions for their communities and patients.

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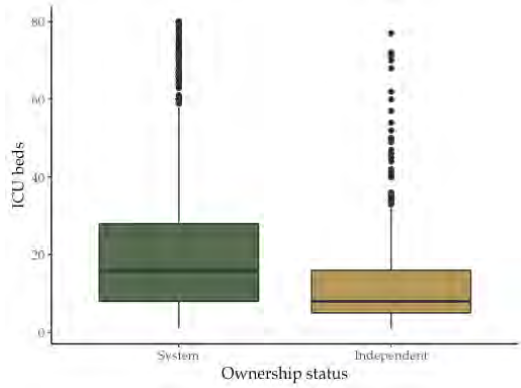
Assessing Hospital Preparedness for COVID-19: A Statistical Approach

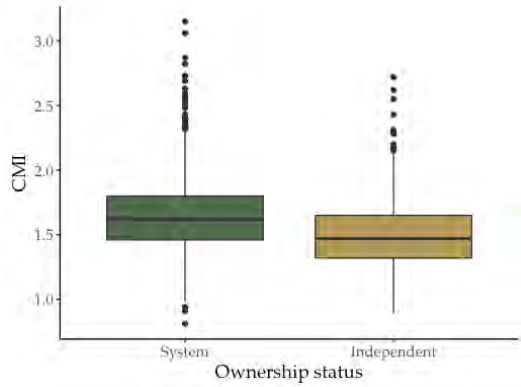
By Jordan Shields, Andrew Blank, Alexandra Normington and Alex Voss

System hospitals tend to have more ICU beds, higher case mix indices and are more likely to be a part of a Clinically Integrated Network (CIN) or Accountable Care Organization (ACO) comparable to standalone hospitals. These attributes are particularly important findings during the COVID-19 pandemic, where ICU beds are at a premium; experience managing complex cases is essential; and the ability to care for patients in appropriate settings is of utmost importance.

We reached these conclusions by analyzing CMS Medicare Cost Report data, the most comprehensive set of financial and clinical data available for comparisons of U.S. hospitals. We used this data set to create regression models which are described later in the article. These regressions allow us to assess the impact of independence on ICU beds, CMI and ACO/CIN membership. We performed this analysis on a subset of all hospitals, namely those with 80 or fewer ICU beds. Intuitively, facilities with more than 80 ICU beds tend to be 'hub' facilities and there are almost no independent hospitals with greater than 80 ICU beds. Further, by excluding these 'hub' facilities, we review a data set where both system and standalone hospitals are well distributed (see figure 1) and lower the risk of confused results.

Fig. 1 (distributions):





Distribution: proportion of hospitals in ACO			
	System		Independent
ACO	0.53		0.16
No ACO	0.47		0.84

Distribution: proportion of hospitals in CIN			
	System		Independent
CIN	0.28		0.02
No CIN	0.72		0.98

Distribution: proportion of hospitals in ACO or CIN			
	System		Independent
Either	0.81		0.18
Neither	0.19		0.82

ICU Beds

As it became clear that COVID-19 cases could overwhelm existing intensive care capacity, we wanted to better understand whether being part of a system impacted a facility's number of ICU beds. We generated a linear regression model and compared numerous control variables related to hospital size, profit, independence, payor mix, etc. We tested each generated coefficient for statistical significance. Our resulting model for ICU beds included hospital independence as a variable having a statistically significant (negative) relationship with the number of ICU beds, with the following additional statistically significant control variables:

- Case mix index – higher acuity patients need more ICU beds
- CMS hospital compare score – imperfect, but centralized and available, quality measure
- Discharges – a control for size of the hospital
- Average length of stay –longer stays can indicate intensive care utilization

Holding the above elements constant, we found that, for example, a 100-bed community hospital that is part of a system is likely to have 1.5 more ICU beds than a 100-bed standalone hospital.

Fig. 1a (model):

$$\widehat{ICU} = -1.47 \cdot INDEPENDENCE + 12.40 \cdot CMI - 0.75 \cdot HCOMP + 0.000949 \cdot DISCHARGES + 1.19 \cdot ALOS$$

Fig. 1b (model coefficients):

Variables	Estimate	Std. error
Intercept	*-11.8900000000*	*1.5460000000*
Hospital independence	-1.4700000000	0.5036000000
CMI	12.4000000000	0.8948000000
Hospital Compare score	-0.7514000000	0.1756000000
Discharges	0.0009488000	0.0000265500
ALOS	1.1920000000	0.2241000000

Case Mix Index

Case mix index can be a proxy for clinical preparedness to care for complicated patients. Intuitively, a hospital that regularly treats higher acuity cases will be better prepared for the clinical demands of treating a novel virus than a similarly sized and situated facility that sees less complicated cases. Working with organizations that are considering partnerships, we regularly hear concern that if they join a larger system their facility will become a "band-aid station" sending complicated cases on to a system's larger facilities. At the same time, we hear from past clients who tell us that post-transaction they have added specialized services and beds. These sentiments and anecdotes are contradictory, and we aimed to test the impact of independence on case mix index statistically, having the advantage of a large set of data. We again generated a linear regression model with numerous variables related to hospital size, profit, independence, payor mix, etc. and tested each generated coefficient for statistical significance. Our resulting model for CMI included hospital independence as having a statistically significant (negative) relationship with CMI, with the following additional statistically significant control variables:

- ICU beds – patients assigned to ICU beds typically have higher acuity diagnoses
- Medicare payor mix – associated with comorbidities and higher acuity stays
- CMS hospital compare score – imperfect, but centralized and available, quality measure
- Adjusted patient days – a control for size, incorporating ambulatory reach
- Average length of stay (ALOS) – long stays can indicate complicated cases

A hospital that is part of a system will, on average, have a case mix index that is 0.05 higher than a similarly situated standalone hospital. For the typical hospital in the set with a CMI of 1.62, being in a system predicts a 3% increase. This indicates that systems work to grow their

community hospitals by adding services and keeping patients close to home.

Fig. 2a (model):

$$\widehat{CMI} = 1.255 + 0.00594 \cdot ICUBEDS - 0.05533 \cdot INDEPENDENCE - 0.2144 \cdot PAYORMIXMEDDAYS + 0.03612 \cdot + 0.0000006204 \cdot ADJPATIENTDAYS + 0.03624 \cdot ALOS$$

Fig. 2b (model coefficients):

Variables	Estimate	Std. error
Intercept	1.2550000000	0.0306600000
ICU beds	0.0059400000	0.0003512000
Hospital independence	-0.0553300000	0.0117000000
Payor mix - Medicare days	-0.2144000000	0.0357500000
Hospital compare score	0.0361200000	0.0037170000
Adjusted Patient Days	0.0000006204	0.0000000589
ALOS	0.0362400000	0.0052730000

Accountable Care Organizations and Clinically Integrated Networks

If ICU beds are a proxy for a facility's resource depth and CMI is a proxy for clinical depth, then ACO and CIN participation may be regarded as a proxy for network depth. We wanted to test whether standalone or system hospitals had the network depth to treat contagious patients in the most appropriate location as well as coordinate the care of non-COVID-19 patients. Relative to the other two questions, this is a bit more esoteric, and we had fewer variables from which to choose in the Medicare cost report data set. We selected ACO or CIN participation as a proxy for how acute care hospitals relate to their broader healthcare landscape. To test the statistical significance of being standalone vs. part of a system on likelihood to participate in an ACO or CIN, we generated a logistic regression model. While we had used linear regressions when looking at the impact of 'systemness' on ICU beds and CMI, we used a logistic regression here given the yes/no nature of the predicted variable of ACO or CIN affiliation (yes, the hospital is in; or, no, the hospital is not in).

With the model controlling for operating margin, Medicare payor mix and CMS hospital compare score, we found that being in a system has a statistically significant (positive) relationship with the odds of being a member of an ACO or CIN (shown by the negative coefficient for independence in figures 3a an 3b).

Fig. 3a (model):

$$log(\frac{p}{1-p}) = 0.28379 - 1.84664 \cdot INDEPENDENCE + 0.14163 \cdot HCOMP + 0.30008 \cdot OPMARGIN + 0.89474 \cdot PAYORMIXMED$$

Fig. 3b (model coefficients):

Variables	Estimate	Std. error
Intercept	*0.28379*	*0.17741*
Independence	-1.84664	0.12297
Operating margin	0.30008	0.13404
Payor mix Medicare days	0.89474	0.39221
Hospital compare score	0.14163	0.04112

Conclusions

Contrary to the worries we hear from standalone hospitals, joining a system typically relates to greater local investment in facility infrastructure as measured by ICU bed capacity, clinical acumen as measured by CMI and care coordination as measured by participation in ACOs or CINs. These findings indicate that the highly fragmented nature of our healthcare delivery system hampers its ability to care for critically ill patients.

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II. Organizing for Success

Partnership Roadmap: Navigating Successful Health System Integration

By Ethan Rii, Caitlin Podbielski and Jordan Shields

The decision to align with another healthcare organization is among the most important, if not *the* most important, undertakings for a hospital board. Selecting the right partner, strategy, timing and structure all play important roles in determining the ultimate success of the organization and the partnership.

Choices are made (even in initial conversations) that help determine how the organization will meet the healthcare needs of its communities for years to come. These choices may also influence whether the organization will be successful in meeting its objectives. Complexities inherent in these choices can make the process overwhelming, akin to approaching a five-way intersection without a map. Below are a few "rules of the road" that can provide safe passage and aid leadership in finding the route that ends at the desired destination.

Identify your destination. Organizations often make their first mistake while they are still in the driveway. They do this by identifying a given structure – independence, loose affiliation, full integration into a health system of a specific size, or others – as their "destination."

Instead of driving towards a specific partner or structure, successful organizations develop precise objectives to direct them to the best fit and approach. These objectives set forth the organization's vision for its role, guiding key decisions and leading it towards its ultimate "destination."

In developing such objectives, it can be tempting to focus on near-term considerations: a target for next year's operating performance, growth of a particular service line, reducing medical errors, and so forth. Individually, these goals are appropriate, but they may be insufficient to address longer-term needs. Instead, objectives should be

dynamic and vision-driven, focusing on long-term structural implications, including the effect on cost and quality of care; increasing patient access; navigating the competitive landscape; and strengthening access to capital.

Furthermore, objectives are not static; they may shift or realign throughout the process. Diligent leaders should not be afraid to adjust or challenge the objectives where necessary to keep the organization on an appropriate course.

Chart your course. With objectives guiding the organization to a destination, it is time to pull out the road map. Plan for roadblocks and detours by identifying all actionable alternatives and giving due consideration to each alternative.

One common mistake boards make is to select an option that achieves a singular or primary objective, perhaps to the detriment of achieving others. For example, the organization may have a set of identified objectives, including: (i) improving quality metrics, and (ii) increasing operating margins to support the clinical enterprise. Narrowly focusing on the first objective, the organization pursues a clinical affiliation with a nearby system known for its quality infrastructure. The partnership gives the organization the intended infrastructure, which will enable it to improve its metrics, but the financial benefits associated with the improved quality performance disproportionately accrue to the partner.

As the example shows, a single strategy may have varying degrees of success in achieving each objective, so a process of prioritization must take place. The pursuit of one path to the mutual exclusion of others can have the unintended effect of derailing the organization by preventing it from realizing balanced, meaningful results.

Take the wheel. Board members should be cognizant of the fiduciary duties they owe to the organization that cannot be ceded or delegated, and the board must be careful not to relegate itself to being a backseat driver. It can be tempting to be passive receptors of

information vetted and prepared by management and outside experts as to which affiliation vehicle may be best for the organization. But effective boards take an active role, critically digesting the available information, asking questions and testing underlying assumptions and, ultimately, making a decision.

Pushing for more information or for answers to unaddressed questions is an appropriate role for the board of an organization seeking to embark on such an impactful journey. Furthermore, evaluations should compare multiple strategies against each other, in addition to appraising each alternative's ability to achieve identified objectives.

Avoid the potholes. Along the best-charted paths, there can be unexpected setbacks and mistakes that even the most prepared organizations may fail to recognize. However, there are key steps that can be taken to anticipate possible delays to allow for the least bumpy ride.

Organizations with well-crafted and tended-to objectives and a vetted, charted course will rely on experienced business and legal advisors who can design and execute a process that can navigate both common *and* unexpected detours. Experienced counsel can identify and strategize to avoid or address potential or necessary roadblocks or detours, such as conducting Hart-Scott-Rodino antitrust review, identifying applicable legal requirements that may dictate transactional structure or regulatory approvals that are necessary prior to closing in order to limit revenue interruption.

Business advisors who are well-versed in the industry and marketplace can be invaluable in identifying financial, operating and other risks, such as hidden balance sheet exposure, impact of various structural choices on value, or vulnerabilities associated with a potential transactional partner. Ultimately, a team of experienced advisors can be the most important tool in the organization's emergency roadside kit, permitting the organization to arrive at its intended destination with minimal detours and delays.

Unpack from the trip. Closing the transaction is critical, but it is not the point at which the journey ends. Successful affiliations are defined by outcome and whether the participating organizations are positioned to achieve measurable results in health care quality and access.

Post-closing action items typically focus on the immediate: coordinating reporting systems, linking information technology platforms and rolling out clinical best practices; however, uniformity of policies and procedures alone is insufficient to ensure such success. Integration must go beyond paper and matching uniforms; cultural assimilation efforts reinforced by formal tracking of responsibilities and progress should remain a guiding tenet of the post-closing board's agenda and goals.

Whatever the ultimate destination, the journey will be unique to every organization. Organizations that approach the trip in a haphazard way, reacting to a single alternative, an obvious choice or the unintended distraction, instead of conducting thoughtful diligence to vet a full range of alternatives, are destined to fail. But engaged boards that are prepared with information, experienced support and access to the full range of actionable alternatives have the best chances to achieve success.

Assessing Independence

By James Burgdorfer

Several recent surveys indicate that nearly 80 percent of non-profit hospital boards are assessing their independence. This means they are determining whether to affiliate, combine or remain independent. Only 15 percent of boards were considering this a few years ago. This is the Affordable Care Act's (ACA) greatest impact on non-profit hospital boardrooms today, and much more so than the "flood" of mergers widely described in periodicals.

A recent New York Times article described the FTC's wariness of mergers amongst hospitals quoting an economist who suggested that the ACA has "unleashed a merger frenzy" and that she saw antitrust enforcement as a tool to slow the "march toward conglomeration". Perhaps these assertions were intended to be forecasts. In any event, they are very common misstatements. In fact, mergers are being completed at a tepid rate of around 80 small transactions per year, far below the annual rate of nearly 150 in the early and mid- 1990s. The hospital industry remains the most fragmented major industry in the U.S.

This article focuses on the disconnection between the much-discussed and presumed impact of the ACA, or the "merger frenzy," and actual market developments. The significance of the large proportion of hospitals that are considering their independence has been largely ignored, along with most of the issues associated with this. As a starting point, we will review the reasons boards are studying their independence, the approaches they are taking, the role of governance, and common missteps that are occurring.

Why Assess Independence?

The reasons for considering independence have changed significantly over the past 25 years. In general, pursuit of this topic has gone from a sign of weakness by a relatively few financially challenged hospitals, to a widely accepted and prudent approach being conducted by

the majority of hospitals.

During the early and mid-1990s, the emergence of managed care produced a perceived need to create larger regional systems. Many boards considered independence as a result of this objective, and it drove most of the combinations during this period. It resulted in the most active hospital merger market of the past 25 years, reaching a peak of nearly 200 transactions in 1997. Despite this, far fewer hospitals were considering independence during this time period than today.

In contrast, during the early and mid-2000s, financial challenges made it difficult for many midsized hospital companies to raise capital. This was the motivation for considering independence and entering into business combinations. Combinations occurred at a greatly reduced rate, approximately 30 to 50 per year. In the mid-2010s, the primary motivation for considering independence and combinations has been the ACA, specifically the need for economies and efficiencies associated with scale. The external and pervasive nature of the ACA accounts for the dramatic increase in the proportion of hospitals considering independence. However, as mentioned earlier, this has not resulted in a significant increase in the number of completed combinations or any change in the fragmented structure of the industry.

In addition to the business attributes of scale, there are new and added factors causing some to consider independence. These center on the growing evidence that quality and safety can be improved via the replication and standardization associated with larger companies. Also, dynamics in certain markets (e.g., narrow network formation, physician recruitment and behavior, and existential risks in states without Certificate of Need laws) are stimulating certain hospitals to consider independence.

Responses of Participants

The current merger market began in the early 2010s as passage of the ACA became likely. It features mid-sized hospital companies considering whether to become part of larger companies by affiliating or

combining, and larger multi-hospital systems seeking growth through acquisitions. Beyond these generalizations, the ACA's impact on independence varies significantly by type and size of hospital, as follows:

- **Mid-sized hospitals**, those with approximately $100 million to $700 million in net patient revenue (NPR), are actively considering independence, as described herein, but not yet entering into large numbers of combinations. As a group, these hospitals are more strategically motivated and their boards are less interested in the creation of foundations than in the past.
- **Large systems**, those with more than $2bn in NPR, have become very acquisitive in an effort to achieve scale. Correspondingly, they are developing much greater skill in business combination transactions. Their response to acquisition opportunities has improved noticeably and they are more often commercially reasonable in the transaction terms that they propose.
- **Intermediate-sized systems**, those with approximately $1bn in NPR, are the most enigmatic group. It is difficult for them to decide how to respond to the ACA. Often, they are too large to, at least so far, consider joining a larger company, but too small to be a successful consolidator. As a result, this group is experiencing the least structural change.
- **Small hospitals**, those with $50 million in NPR and less, are experiencing dramatic decline in acquisition interest from larger hospital companies. Many might not be able to find a partner at all. With exceptions, this group faces a very difficult future.
- **Investor-owned hospital companies** appear to be losing their advantage in growing through the acquisition of non-profit hospitals. This is due to intra-sector consolidation that has left only five publicly traded and a handful of private, large investor-owned companies, as well as greater competition from non-profits for acquisitions and the non-financial demands of strategically motivated sellers. The best success for this group is coming through their participation in buyer joint ventures.

Approaches to Assessing Independence

Secondary research involves a review of one's financial circumstance

and market position. It does not seek input from market participants (i.e., primary sources). Non-profit hospital boards have historically relied exclusively on secondary research as they considered their independence. Generally, it is the first inclination of managements, boards, consultants and attorneys. It is a very worthwhile approach and almost a necessity. However, if conducted in a vacuum or in the wrong hands, it can be used in harmful ways.

Recently this form of analysis has been misused by boards to make curious decisions. Particularly troubling are those that are based upon forecasts of sharply improved operating results, notwithstanding very obvious operating and financial challenges. Also, this approach is sometimes used merely to substantiate the original inclination of boards rather than openly explore alternatives (more on this as we discuss "missteps" later in this article).

Primary research is a developing alternative that centers on receiving market input as a component of a board's diligence in considering independence. It has only recently become an alternative, perhaps because of the greater social acceptance of considering independence. By seeking real input from market participants, more ideas and a greater understanding of reality can be achieved. It can also be a very useful tool for boards to gauge the market's relative willingness to provide sought-after objectives under affiliations, where no ownership or control is exchanged, versus business combinations, where some or all of ownership and control is exchanged.

Governance

There are important differences in the approaches that non-profit boards and corporate boards take to the topic of independence that should be noted. Non-profit boards are typically made up of volunteers who are local, and the composition of the board is self-perpetuating. Most notably, board members are not elected by owners. As a result, while there is no lack of sincerity and purposefulness, there is no direct accountability in non-profit boardrooms. Additionally, attorneys general focus primarily on conversions (i.e., combinations between for-profits). Taken together, these factors create circumstances

under which well-intended and earnest board members participate in major decisions in an environment influenced by group decision-making dynamics, ideological thinking and an absence of accountability.

In considering independence, the relationship between management and the board differs dramatically from the corporate setting. Boards of many publicly held corporations exclude CEOs from discussions and decisions regarding change-in-ownership due to the potential for conflict. In non-profit hospital boards, just the opposite occurs; management usually initiates and leads consideration of this topic. This seems appropriate given the makeup of boards and the complexity of business. It is, however, a point that boards should be aware of.

Non-profit boards functioned well in the past when hospitals were local missions and even as they became local businesses. They are particularly adept at philanthropy and local matters. However, they are often not functioning as well in responding to the structural challenges inherent in the ACA and resulting from other competitive pressures since its passage into law. Understandably, their focus often centers on avoiding change. As a result, management must initiate discussion of this topic in most cases.

Missteps and Transaction Mistakes

Missteps

Missteps are increasing as more hospital boards consider independence. These occur both publicly and privately. In either case, they usually lead to a decline in outcomes, value, and missed opportunity. Public missteps often involve entering into exclusivity arrangements either prematurely or inappropriately relative to the public announcement related to it. These are occurring frequently. For example, recently a mid-sized Midwestern hospital announced that it was going to return to the merger market to seek a partner after spending a full year in exclusive discussions with a major academic system regarding a business combination. This type of delay under public scrutiny need never happen; it is harmful to the hospital and the

community. Sadly, we doubt that management, the board or the community have any awareness of the harm of this sequence or its repercussions.

Private missteps are more difficult to detect, but we hear of them frequently in our work. They are often an outcome of managements and boards relying on forecast dramatic improvements. This, too, can lead to poor decisions and decline in value. In other cases, illogical transaction structures are attempted. These usually reflect well-intended but fruitless efforts by boards to retain governance independence or significant participation in future governance of the combined enterprise.

These missteps generally result from the complexity and external nature of the merger market. Managements, boards and consultants with little experience in this market often engage in time-consuming, expensive and meandering reviews. Group decision-making dynamics and ideology only act to compound the challenges.

Transaction Mistakes

These have also been occurring at a surprising rate, perhaps as high as 20 percent of announced agreed-to combinations. These are harmful events in which hospital companies, after considering independence, select a partner of choice, and enter into a letter of intent and make a public announcement describing the potential combination. However, the transaction does not close. These are enormous mistakes that lead to loss of value, opportunity, and a whole host of operating challenges. They are usually preceded by faulty assessments of independence and result directly from poorly designed processes regarding partner selection. From a broader view, these missteps and mistakes are reflective of early stages of change in a fragmented and tradition-bound industry. They rarely occur in the corporate world where there is greater familiarity with the merger market and accountability to ownership.

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Preparing a Hospital or Health System for Sale or Partnership Transactions

By Rex Burgdorfer, Jordan Shields, John Callahan, Megan Rooney and Krist Werling

The consolidation trend in hospital and health systems continues. At this time, horizontal consolidation (hospital to hospital combinations) are keeping pace with vertical consolidation (hospital acquisitions of ancillary providers and physician groups). To address perceived inefficiencies and quality of care issues, hospitals are attempting to form larger enterprises to create scale, expand geographically, manage risk, access capital, contend with the changing regulatory environment and to more effectively manage the health of the populations they serve. Despite the trend toward consolidation, completing hospital consolidation transactions is more challenging than ever as demonstrated by an alarmingly high failure rate. Over the past several years, about 25 percent of announced partnerships have failed after the signing of a letter of intent and before close. A "busted deal" may cause economic harm and operating disruption to all involved.

One of the keys to assuring that a hospital transaction can be successfully completed is advance preparation. Advance preparation mitigates two key risks. First, preparation mitigates risk of delayed closing or a sidetracked deal due to the discovery of a regulatory issue during due diligence. Second, preparation can help mitigate against the risk of a "re-trade" on fundamental economic terms. Presenting potential issues (and their solutions) early helps to ensure that the terms of the transaction take into account all of the known risks associated with the operation of the hospital partners. Preparation can lead to a swift and more painless closure of hospital transactions at attractive valuations, thereby maximizing community benefit and the outcome for all stakeholders.

The following issues should be addressed before a hospital or health system begins discussions with potential partners:

1. Bond Issues

While hospital transactions sometimes are motivated by an actual or impending bond covenant default, bond covenants also often restrict the ability of health systems to enter into transactions with potential partners. In transactions in which a non-profit health system is acquired by a for profit hospital management company, tax exempt bonds usually are fully discharged out of the transaction proceeds, making the bond covenants less relevant. However, in transactions between non-profit health systems, it is common for tax exempt bonds to remain in place for some period of time post-closing. If the bond trustee has a right to consent to the transaction, the parties must plan early to seek the consent. If the bond trustee withholds consent, the parties may need to refinance the debt contemporaneously with the closing of the hospital transaction, even where there otherwise might be financial reasons to wait.

Non-profit health systems which are acquirors also can face bond covenant issues. In many cases, bond indentures require the maintenance of certain financial ratios which can be violated if the balance sheet of the acquired hospital is consolidated. Bond covenants also often restrict health systems from assuming additional debt (such as the bond debt of the acquired hospital). In cashless member substitution transactions between non-profit health systems (i.e., transactions in which the parent of one health system becomes the corporate member of the other health system's hospitals), the acquiring health system often makes commitments to fund routine or special capital projects on the acquired hospital's campus. Before committing to make these capital expenditures, the acquiror should ensure that its own bond covenants do not place restrictions on the amount of capital that can be spent on projects outside of acquiror's bond obligated group.

Regardless of the type of the structure of the transaction, all parties to hospital transactions should be aware of the restrictions imposed by their bonds before they consider potential transactions with partners. In addition to ensuring that there are not delays associated with the unanticipated bond approvals, the parties can develop transaction structures that account for the restrictions, or alternatively, account

for the need to refinance.

2. Pension Plan Deficits

Underfunded pension plans present an issue when negotiating change of control transactions. If a pension plan is significantly underfunded, that is to say that the benefit obligations under the pension plan exceed the assets held in trust to settle the accrued benefits, the pension plan represents a concern both from a liability and cash flow perspective. In many transactions, the affiliating party may adjust its financial commitment to reflect the negative credit impact of underfunded pension plans. In hospital transactions in which a hospital's assets are sold to a buyer, the buyer will likely exclude the underfunded pension plan from the transaction so that it is not legally obligated to maintain or fund the pension plan following the closing.

The seller may be required either to maintain the underfunded pension plan, or alternatively, to fully fund and terminate the underfunded pension plan (which can be expensive). From a buyer's perspective, the termination of these pensions may pose employee relations issues, or require a delicate negotiation with labor unions (potentially delaying the closing of the hospital transaction).

Prior to approaching buyers or partners, a selling hospital should have an actuarial study commissioned on the cost to fund-up or terminate the pension plan. A buyer must understand how pension liabilities will impact the preferred structure of a transaction and the operations of the acquired hospital post-closing.

3. Physician Referral Source Relationships

Large non-profit systems and for-profit consolidators alike heavily scrutinize physician referral source relationships because the financial impact of noncompliance can be substantial. In many situations, an acquiring hospital or system will require the target hospital to self-disclose any inappropriate financial relationships with physician referral sources to regulators prior to closing. This has been demonstrated in a number of recently announced settlements that preceded transactions. For example, Condell Medical Center in Illinois paid a

$36 million settlement for violations of the False Claims Act that emanated from alleged below-fair-market-value leases and other alleged improper financial relationships with physicians prior to Condell's merger with Advocate Health Care.

In preparation for any transaction, hospitals should identify physician and institutional referral sources, consider whether a financial relationship exists and assess whether the relationship is compliant with the anti-kick-back statute and Stark law, as well as applicable state laws. Relationships that should be examined include physician employment agreements, leases, medical director agreements and supply agreements with physicians. Noncompliant relationships should be identified and corrected and, if necessary, self-disclosed to the appropriate regulator.

4. Errors and Omissions (Malpractice) Coverage and Tail Insurance
Most buyers of hospitals will require that a target obtain an insurance policy (or an endorsement to an existing policy) that provides coverage for past known and unknown medical malpractice claims. This type of policy is commonly known as a "tail insurance" policy. The cost and structure of a tail insurance policy can vary widely. One of the key influencing factors on the cost of such a policy is the cost of errors and omissions insurance in the state in which the hospital operates. If the hospital's malpractice coverage (also known as "errors and omissions coverage") was expensive, the tail insurance policy will likely also be costly. If a hospital that is being acquired maintains its own captive malpractice insurance or is "self-insured" it may complicate the approach to tail insurance and there will be a need to purchase tail insurance for the captive's re-insurer. Finally, different features of the tail insurance policy itself (such as whether the policy includes demand or incident triggers) can influence its cost. Hospital management that is preparing for a consolidation transaction should be aware of the structure of its coverage and options for obtaining tail insurance.

5. Licenses, Permits and Accreditations
Two key issues should be examined before a transaction with respect

to licenses, permits, and accreditations. First, all of these governmental permits should be up-to date and, if possible, unrestricted. Any recent suspensions or investigations by regulators should be closed out and the seller should have evidence available to the buyer that no restrictions are in place. Past licensure problems or survey hiccups should be fully remediated, and the hospital should be prepared to explain how survey deficiencies were addressed and how the hospital has improved upon its business and/or clinical practices. A hospital should be able to demonstrate improvements to policies or successful follow-up audits to enable a potential acquiror to feel comfortable that a past problem has been resolved in a reasonable manner.

Hospitals also should research in advance how a change of ownership transaction will impact any of its licenses or permits. Certificate of Need approvals or exemptions, state department of health notices, DEA notices, FCC licenses and Joint Commission or other accrediting body issues should be understood so that acquirors and the hospital's leadership can accurately convey the timeline to stakeholders.

6. Program Integrity Contractor Audit
All hospitals are dealing with the rash of Medicare and Medicaid program integrity contractors such as Recovery Audit Contractors (RAC) and Zone Program Integrity Contractors (ZPIC). Billing and coding is an obvious area of interest for potential acquirors because it impacts not only compliance, but also the quality of the hospital's earnings and cash flow. The importance of cleaning up old program integrity audits, both internal and external, cannot be overemphasized. A hospital must be able to demonstrate that issues identified in old billing and coding audits (whether internal or conducted by Medicare or Medicaid) have been addressed and remediated. To this end, a hospital may want to consider conducting a re-audit by an outside professional or consultant to demonstrate compliance. Even if exposure seems minor, buyers often view any governmental billing and coding issues as significant.

7. Commercial Insurance Relationships
Commercial insurers (i.e., Blue Cross Blue Shield, United Healthcare,

etc.) still pay for the majority of healthcare services provided in the United States. Therefore, sellers should ensure that contractual relationships with these insurers are in order. Specifically, major payor contracts that are expired or near expiration should be re-contracted so as to mitigate against future reimbursement risks. One key issue that health care services companies have faced is the waiver and discounting of patient copayments and deductibles. Commercial insurers maintain out-of-network policies that apply to patients who visit out-of-network providers. In the case of non-compliance with an insurer's policy, a seller should consider a preemptive change, rather than waiting for the acquiror to later reduce its financial commitment when it discovers that the hospital's revenues are inflated due to non-compliance with an insurer's policies.

8. Compliance Program

In the highly regulated health care industry, acquirors will be interested in evaluating a target hospital's healthcare compliance plans, programs and practices to ensure that a "culture of compliance" exists. A seller should expect and be prepared to respond to questions about the compliance plan and the leaders of the hospital's compliance program.

Typical questions may include:

- Does the hospital keep a log of reported compliance issues and how they were addressed?
- Has a recent risk assessment been conducted and has the compliance plan been updated following the risk assessment?
- When is healthcare compliance and privacy training completed for employees and physicians?
- Do hospital board minutes reflect senior management's attention to healthcare compliance issues?

Involving the hospital or health system's compliance professionals early is the key to successfully preparing for these inquiries.

9. HIPAA and Patient Privacy

HIPAA, as supplemented by the Health Information Technology for

Economic and Clinical Health (HITECH) Act, and the patient privacy obligations thereunder, must be a compliance focus for all hospitals. The Office of Civil Rights of the Department of Health and Human Services has begun to audit and fine hospitals for HIPAA violations. For example, Shasta Regional Medical Center in California recently paid a $275,000 fine and agreed to implement a costly corrective action plan due to alleged violation of the HIPAA security rule. To avoid potential HIPAA enforcement issues, a hospital should have updated HIPAA and HITECH Act compliance plans, notices of privacy practices and breach protocols, and, just as importantly, have the ability to demonstrate effective implementation of such plans, practices and protocols. Buyers and potential partners will conduct due diligence on these critical patient privacy issues to avoid successor liability issues.

10. Real Estate Restrictions

Hospital real estate may have been donated many years earlier and can be subject to restrictions on operation and/or transfer. This is of particular concern in transactions where non-profit hospitals are converted to for-profit status. In many cases, deed restrictions can limit the use of land or buildings to charitable or non-profit uses. These restrictions also can include reversionary interests which direct that the land or buildings be returned to the original donor or to the state if the hospital is no longer used for charitable purposes. In other cases, zoning restrictions, non-competition covenants, easements and encumbrances on the title to real property can impact the ability to sell the property, to change the current use of the property or to use the property as collateral for future hospital financings.

Consequently, a hospital must identify and review all real estate restrictions (including restrictions in lease agreements) to understand their potential impact on transactions. Where there are material restrictions on the use of the hospital's main campus, the hospital may select potential transaction partners based upon their ability to comply with the restrictions, or alternatively, may petition a court to loosen or remove the restrictions before the transaction with a partner is consummated. If a hospital is unaware of the restrictions at the time they select a partner, however, it may be unpleasantly surprised

when the real estate restrictions come to light during the due diligence process, potentially delaying or derailing the transaction.

To position a hospital to capitalize on increased integration activity, hospitals considering a sale or integration with a system are urged to review these issues in advance of any transaction. Before a hospital starts discussions with suitors, the critical issues of referral source relationships, patient privacy and billing and coding should be audited and any aberrations addressed. Management should have a strong understanding of pension and bond obligations and options for tail insurance coverage. This preparation and implementation of corrective actions will translate to fewer repricing events and obstacles to a timely closing, thereby enabling maximum value to be achieved for all stakeholders.

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Mergers, Acquisitions & Strategic Partnerships in the New COVID-19 Era

By Isaac Squyres

It's no understatement to say that the healthcare industry will not return to what it was before the world was swept up in the (hopefully) once-in-a-lifetime storm known as COVID-19.

From a business perspective, two questions are being carefully considered:

- What does the M&A landscape look like in the short-term as the healthcare industry begins to adjust to the new pandemic-reshaped environment?
- What is the transactions outlook in the long term as the industry settles into that new framework?

The following thoughts consider these questions from our vantage point as one of the nation's top 10 strategic communications consultancies for healthcare. Our firm focuses exclusively on supporting hospitals, health systems and providers and has handled communications for more than $60 billion of announced transactions and partnerships over the course of the last 14 years.

Here's what we know to be true now more than ever: Healthcare providers hold a unique, emotional position in their communities that lies at the intersection of community health, business and politics. Any successful transaction must be built on a campaign approach, communicating clearly to all stakeholders and earning support for the hard decisions necessary to provide care in a community.

The Pressure Cooker is Hotter and More Intense than Ever

Those of us in the healthcare world live and work in a near constant state of change of some form or another. Regulatory. Technological. How care is paid for in our country. The list goes on. It was daunting before COVID-19, and now the stakes are even higher.

Studies conducted at the height of the coronavirus pandemic in March and April of 2020 suggest that as much as one quarter of rural hospitals could be at risk of closing due to lost revenue. Lack of elective surgeries, particularly in what remains a largely fee-for-service model, has devastated hospitals already struggling under tight margins. These organizations are now under increased pressure to find the right path forward.

Hospitals of all stripes, of course, deliver critical services – both as healthcare providers and economic engines within their communities. Yet on the other side of the equation, larger systems that were better resourced (financially and with human capital) and able to weather the storm will have an opportunity to expand through acquisitions of newly distressed facilities. While the mechanics of and underlying reasons for these transactions haven't changed, the concentration of potential opportunities is likely to be greater than anything we've seen before.

Thus, for the vast majority of health systems, the future will include some of form of new partnership, affiliation, acquisition or transaction. Hospitals must make the case for their essential role as they seek out these changes; even – or perhaps especially – when facing bankruptcy or other significant challenges. All too often the foremost questions asked when in the pursuit of a transaction is about change. *How will the deal will change the care provided? Change the organization that is being sold? Change the way the organization serves its community?*

Instead, the question that should be asked is, *Can care continue at all without the transaction?* That difficult conversation is important and can help frame the way the entire transaction is perceived. It is political leverage that should not be avoided or discounted in this new healthcare landscape, and it provides context and value for both sides of a transaction.

That case must be made quickly. This is not a moment in which the majority of transactions will be built from a strategic desire – for example, one organization wants to sell and seeks out a buyer, or two

partners discuss the benefits of a merger and then execute it. Instead, to be blunt, we believe the post-COVID-19 M&A landscape will be filled with transactions of necessity. Survival or closure. As a result, there is no time to waste in educating stakeholders and building the case for a transaction. A thoughtful, but rapidly developed and deployed communications plan, is essential.

Based on our deep experience and best practices, we've developed a roadmap to help ensure such efforts achieve their objectives for all involved.

It's (Still) All About the Politics of a Deal

Not every deal makes it to the finish line. Not all the ones before the pandemic and not all that will be attempted in its wake. A *HealthLeaders* survey in 2019 found that the top three operational reasons for deals failing included:

1) Mistrust between parties (30 percent)
2) Concern about governance (27 percent)
3) Incompatible cultures (21 percent)

When you add to the mix "concern about fate of organization's mission" (13 percent) and "lack of community support" (6 percent) you glean a pretty clear picture that the politics of people requires a tremendous amount of attention – and the right communications strategy and execution – to get a deal done.

There is every reason to believe these risk points will hold true in the post-COVID-19 M&A world. In fact, these challenges may be even more pronounced.

Union activity looks to be on the rise. Physicians and nurses will be looking for security and will demand a seat at the table, making their now-even-more-powerful voices heard. The general public will likely have come to believe even more strongly that "their" hospital is the

community savior and must be protected in its current form. The list of challenges has lengthened.

You may be asking, "Sure, but won't the 'bigger is better' narrative easily trump the concerns that people have?" The answer to that, well… is complicated.

Yes, the importance of size and scale has been drawn into stark relief thanks to COVID-19. Virtually everyone, including the average person on the street, has now been exposed to the importance of supply chain thanks to PPE, ventilators and more. Likewise, having the right mix of beds in a hospital's capacity arsenal will help to support the size-and-scale argument in a way that people will likely appreciate more than ever before.

While a "bigger is better" narrative may be potentially easier to accept and buy into today, getting a deal done isn't a foregone conclusion.

The reality is that hospitals and health systems, even in a post-COVID-19 world, have an enormous number of stakeholders who need to be managed: physicians, employees, patients, regulators, elected officials, the media, business leaders and so many others.

These stakeholders all bring to a potential deal their unique perspective that comes from an emotional and personal place. The result is often a politically-charged environment.

Not Big "P" politics, but little "p" politics: the politics of people.

And you count on this: After months of healthcare issues dominating every facet of our lives, emotions will be running even higher than normal when it comes to questions about what the future of healthcare in a community looks like.

Ironically, and in contrast to the financial struggles many hospitals are facing, their political clout has increased. This should be leveraged. New models of care (including existing trends towards outpatient clinics and ASCs plus those accelerated by the pandemic such

as telehealth and hospital-at-home) are likely to disrupt the classic model of inpatient demand dictating a hospital's financials. With such a high percentage of rural hospital revenue coming from outpatient services, their political value could increase even as their financial situation becomes more tenuous. For a hospital considering a sale, communicating that value, and putting it into the context of how it can contribute to the buying system, is a powerful card to be played.

The Value of a Strategic Communications Approach Based on Political Campaign Principles

The value of a strategic approach to communications through the deal process lies in generating excitement and understanding of what the prospect of the deal means for the future of healthcare, as well as allaying the fears that people have.

Our work is about getting the people politics right, keeping the waters calm and the noise manageable.

We take a political campaign approach to our work, using a set of tried-and-true organizing principles to drive the work forward toward a single win. We leverage multiple mediums to deliver messages that are compelling because they are delivered by credible messengers and reflect the issues that matter to stakeholders. Everything is tightly coordinated against a timeline. And ultimately, we focus on building and using relationships to make change happen.

It's worth noting that these ideas are often even more important in a deal involving a community or rural facility. In small communities, life is already all about relationships. The hospital board consists of local businesspeople, often those whose roots run deep. Everyone knows everyone. Word spreads fast, and opinions are shaped rapidly. Transparency is paramount because if an organization does not explain what is happening and, especially, why it's happening, other sources will fill that void.

Furthermore, there's little distinction between internal and external audiences. Hospital staff, leadership and board members are being asked what is happening and what it all means when they are at church, the grocery, the PTA meeting. In this closed-loop system, carefully defining the message and picking the right messenger(s) to deliver it, and then repeating it consistently and empathetically, can be the difference between rallying support or causing confusion and even outrage. Either way, the response of the community can have a significant impact on the immediate and even long-term success of a transaction that does go through.

Ground Rules

There are some ground rules that we have learned over time, and we believe they're even more critical in a post-COVID-19 world:

1. You must own the message
2. Emotions trump facts
3. The messenger is a message
4. You must speak with one voice
5. Start internally and build outward
6. Meet people where they are
7. Be flexible and work to over communicate
8. Be responsibly transparent
9. Think like the opposition (there will always be opposition)
10. Don't dance to someone else's music

These ground rules are all important, but let's focus on a couple of themes that drive successful deal communications.

The Message: Own it, tie it to emotion and coordinate who delivers it using a steady drumbeat that always begins internally and meets people where they are.

It's hard to get anything done if you are not able to clearly, and in a compelling way, explain the why of what you're setting out to do. That's why it's critical to have the right message.

It must be tied to emotion and meet people where they are. Yes, you have facts and those are important. But ultimately, you must connect with people on an emotional level to make it resonant and be meaningful to them.

We've all been in a situation where we've heard words delivered by someone that we don't necessarily view as credible, right? That's why it's extraordinarily important to understand that the messenger is a message in and of itself. Nurses, physicians, board members are all important messengers because they're viewed with high credibility.

Responsible Transparency: More than a buzzword, the information that's shared must be strategic.

Responsible transparency requires that you are smart and thoughtful about the specific information you're sharing, how it's shared, when it's shared and who is sharing it. Certainly don't share information for the sake of sharing it. It must be strategic. That's how you achieve responsibly transparency.

The Opposition

Our experience is that there is always some level of opposition to a deal, be it internal and/or external in form. The challenge then becomes mitigating opposition, keeping people neutral and – if possible – using communications to turn opposition into support. Physicians can kill deals faster than anyone, for instance, and COVID-19 has increased the power of the physician voice. Beyond physicians and other internal audiences, and as was mentioned above, COVID-19 has driven up the perception of the importance of local hospitals in the minds of the public. Communities were paying attention to deals before, but the public scrutiny will be even greater moving forward. It must be dealt with smartly from a communications and stakeholder engagement perspective. The campaign approach provides a proven way in which to approach this critical work.

Change will happen – in healthcare as in every other aspect of life. The question is never, "Will things change?" but "How will things

change?" and, "Who will drive the change?" In our experience, using a campaign approach to communications helps providers lead in high-stakes moments, rather than get pulled along. Whether a transaction is borne out of deep distress and necessity or out of strategic opportunity, the principles above will allow you to take events over which you have no control (consider, for example, a global pandemic) and leverage them towards an outcome that creates value and maintains your mission.

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Developing a Hospital Transaction Strategy and Process

By Rex Burgdorfer, Jordan Shields, John Callahan, Megan Rooney and Krist Werling

Pursuing a transaction is among the most significant actions that a hospital board and management team can undertake in the life of an institution. It also is the riskiest. Economic and non-economic stakes are high, including preserving the hospital's mission and charitable objectives, safeguarding access to care, ensuring quality and protecting employees. A well-run merger process maximizes board objectives and avoids critical missteps.

This article identifies key components of an effective transaction process. Successful organizations start with their mission and clearly articulated medium and long-term objectives. They then complete a comprehensive options assessment, identifying the full range of strategic financial alternatives. By pursuing an organized transaction process, organizations can devote attention to pursuing alternatives best suited to fulfill their mission and meet their objectives.

Developing Objectives

The first step for a non-profit hospital board considering any hospital transaction is to clearly articulate its charitable objectives and goals for a potential transaction. Not only does this process help focus the board, it can be critical for approval of the transaction. In many states, hospital transactions are subject to state attorney general or other regulatory approval, and the hospital will be required to demonstrate that at every step of the process the organization's charitable objectives and goals guided decision-making.

To help articulate specific charitable objectives, management, often with the help of an outside advisor, can assess the needs of the market. This typically entails a review of market demographics, growth trends, referral patterns and other market characteristics. Second, organizational offerings are matched against the needs of the market. If

there is a gap between market demand and organizational offerings, filling that gap often rises to an organizational objective. These gaps can be both qualitative and quantitative. For example, improving poor population health outcomes could be a qualitative objective, while improving quality metrics or adding a service could be quantitative objectives.

When boards fail to clearly articulate objectives and hold themselves to the pursuit of those objectives, organizations find themselves chasing short-term solutions to systemic problems. This manifests itself with hospitals that define "independence" as an organizational goal without tying it to any of their articulated objectives. The result is hospitals that accept poor quality or deteriorating financial positions as a condition of a changing healthcare environment instead of dispassionately assessing how to ensure access to efficiently-delivered, high-quality services for the community.

It is rare for an objective to have a predetermined solution. Instead, an organization's objectives typically allow for a range of strategies and tactics. It is a mistake to jump to a given partner or structure at this stage, and the organization should undertake a thoughtful assessment of its full range of strategic financial alternatives through a carefully structured options assessment.

Options Assessment

Boards are best able to assess their situations and choose the optimal path for their organizations when they simultaneously consider the full range of strategic alternatives available. To do this, Boards should complete a situation review considering the internal factors that will impact future success, as well as the external choices available to them. Internal factors include strategic position within primary and secondary service areas, forecasted operating and financial performance, solvency analyses, access to capital and an assessment of business value. This exercise reviews the organization's qualitative and quantitative gaps and identifies structures to meet those gaps.

The situation review should consider nonrecurring market-centric

issues as well as recurring hospital-centric issues. Market-centric issues include the structure of the healthcare industry and how that structure is changing. These market forces are then considered within the context of the hospital to assess business value, debt capacity, expected changes to reimbursement and other financial and operational shifts to which the hospital will need to respond. Hospital-centric items include the organization's financial condition, physical plant condition, competitor activity, physician relations and strategic position. The situation review should also consider activity within the regional market and assess how that activity will impact the hospital's ability to meet its objectives.

At this point in the process, it is important for boards to begin consulting with experienced antitrust counsel. Antitrust counsel is important for two key reasons. First, the board should be educated about the "do's and don'ts" of antitrust laws prior to beginning to discuss and document consolidation options. Even in early-stage strategic discussions, board, management and their advisors should avoid definitive statements about the ability to assert pricing power or market domination of certain types of procedures or patients. Second, boards and management should consider how the Federal Trade Commission and state antitrust regulators will view a potential combination. Boards should consider how managed care organizations might react and what efficiencies should be obtained from a potential combination. Furthermore, if a hospital is experiencing severe financial difficulties, antitrust counsel should be consulted to determine how financial data would be presented to the FTC to justify certain transactions. In some cases, informed antitrust advice also will allow a board to consider whether transactions with certain partners will be more difficult to execute from an antitrust perspective than others.

This situation review feeds into a formal options assessment. Within the context of the hospital's situation and objectives, the board should review the full range of alternatives available. This includes all of the alternatives available that do not include a transaction, like a contractual or branding affiliation with a larger system, divesting noncore assets, entering into a joint operating agreement or participating in an

accountable care organization. The range also includes alternatives like a seller-joint venture or a long-term lease. A seller joint venture allows the hospital to sell a portion of the business, but maintain some governance input. A long-term lease maintains ownership, but transfers operational control for an upfront payment. Alternatives like a consolidation, where two hospital companies come together to form a new jointly governed system, should also be considered. Finally, alternatives that include a full change of ownership and control should be evaluated. These include a merger with another non-profit system or an outright sale, typically to an investor owned company or a buyer joint venture.

It is important for the board to keep an open mind throughout the options assessment. This process is designed to be exploratory and to uncover the full range of available alternatives. A common mistake of organizations that carefully develop their objectives but do not pursue a structured options assessment is that they bounce from one narrow tactic to the next. Instead of stepping back and evaluating their situation within the broad context of the market, they will pursue one-off fixes designed to fill a single gap without addressing their long-term strategic and financial positions.

Designing a Process

If the options assessment recommends the exploration of partnership structures, a controlled competitive process should be considered to solicit interest from the market. This process should be specific to the hospital and will vary based on local dynamics, but should include the following components:

Gradual and comparative

The process should allow for thinking to evolve as more is learned about potential market options. Instead of attempting to solve for the best outcome upfront and in a vacuum with limited real-time market input, decision making should be iterative and allow for the priorities of the hospital's objectives to change over time as actionable alternatives are explored and vetted.

Scope of discussions
Unless there is a specific reason to exclude a particular partner or structural alternative from discussions, the process should be inclusive of all reasonable alternatives. A broad scope can help to demonstrate that the board considered all options to fulfill the charitable mission of the organization. Even if a given partner or structure does not ultimately prove to be the organization's best match, its offer may identify attractive alternatives that would not otherwise have been considered.

Timing
The timeline for the process should be designed to the organization's benefit. A detailed timeline, minimizing risks inherent to the process, should be developed before embarking on a process. If a situation arises mid-process that compels a deviation from the timeline, care should be taken to balance the risks and benefits related to that deviation.

Strategic options committee
Establishing a board committee to oversee the process can help to provide consistent input, improve oversight and increase responsiveness. The strategic options committee should regularly report to the full board and, when the time is right, the full board and management should have ample opportunity to screen finalists in person for cultural, physician, operating and vision fit. It is the role of the board's advisors to manage the process, ensuring the effective use of the committee's, management's and board's time.

Competition
In many situations, competition can help organizations maximize economic and non-economic value. This can be helpful in demonstrating to state regulators that maximum value was obtained for the assets of the non-profit. As important as ultimate regulatory approval, a well-run controlled competitive process also ensures the board that it has selected the option that best meets its objectives.

Conclusion

Successfully executed transactions can appear deceptively simple from the outside. In fact, they are highly complex orchestrations, taking place in challenging operating and regulatory environments. The economic and noneconomic ramifications for hospitals and the communities they serve cannot be overstated.

By following carefully designed processes, boards and management can mitigate transaction risks and maximize value. Successful transactions begin with the development of clearly articulated objectives that support the hospital's charitable mission. By considering the full range of structures and partners, hospital boards achieve the basis of comparison necessary to choose the alternative that best meets their objectives.

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The Role of the Non-Profit Hospital Board in Consolidation Transactions

By Michael Peregrine, Megan Rooney, Krist Werling, Rex Burgdorfer and Jordan Shields

As the hospital consolidation market continues to grow, most consolidation transactions involve non-profit health systems. Non-profit boards of directors should prepare well in advance to evaluate consolidation opportunities in a timely and informed manner, consistent with their fiduciary duty.

The hospital consolidation market continues to gain steam. The year 2019 saw a total of 91 consolidation transactions, following years of sustained transaction activity since 2010.

This volume represents a significant increase over 58, the median number of transactions completed each year between 2001 and 2011. Consolidation transactions offer the possibility of achieving economies of scale, better access to capital, geographic expansion, and improved quality and clinician expertise. The vast majority of consolidation transactions involve a non-profit health system. In such cases, ultimately it is the non-profit board's decision whether, and under what terms and conditions, a hospital pursues a consolidation transaction.

It is critical for a non-profit board of directors to prepare in advance to evaluate a consolidation opportunity in a timely and informed manner, consistent with its fiduciary duty.

Doing so requires the board to, at a minimum, undertake the following preparation:

1. Be informed about the fiduciary obligations incumbent on the directors;

2. Establish good governance processes well in advance;

3. Make provisions to address certain regulatory and business issues common to consolidation transactions

The law expects the board to closely oversee the transaction process in order to preserve them value of the corporate assets and to protect the charitable mission. Failure to provide sufficient oversight will weaken the credibility of the board's ultimate decision and imperil any board-endorsed deal's chances for regulatory approval. Corporate conventions related to business combination decision-making policies offer good guidance for hospital boards. Several decades of case law and well-developed M&A market experience can provide meaningful direction for the new wave of hospital directors confronted with evaluating similar change-of-control opportunities.

The Board's Fiduciary Obligations

The board of directors of a non-profit health system or hospital has three core fiduciary duties: the duty of loyalty, the duty of care and the duty of obedience to the charitable mission of the organization. These three core duties apply to the governing board as a whole and its various committees and subcommittees. The fiduciary duties are not for the benefit of other board members, donors to the hospital, executives or physicians. Instead, these fiduciary duties are owed to the organization itself and its charitable purposes. Therefore, non-profit directors are bound to serve the best interests of the organization itself, and not another constituency.

The Duty of Loyalty

The duty of loyalty requires corporate directors to exercise their powers in good faith in furtherance of the charitable mission and not in their own interests or the interests of another person or entity. In the context of evaluating a potential consolidation transaction, the duty of loyalty imposes an obligation on directors that they not consider other interests in making the decision. Furthermore, directors are obliged to keep confidential the presence and mechanics of a transaction process and the details thereof for the benefit of the organization. For example, the impact of a consolidation on certain physician

groups or staff should not be put before the goal of furthering the organization's charitable mission.

The Duty of Care

The duty of care requires that corporate directors act in an informed, good faith manner when participating in board decisions and exercising their oversight of the organization. The duty of care applies not only to oversight of day-to-day operations and compliance issues, but also to the evaluation and oversight of consolidation transactions. Some states may hold a "seller's" board to an even higher standard of care. To fulfill the duty of care, corporate directors are encouraged to allow sufficient time for consideration, to gather and review all relevant data (including primary source data), and to ask questions in order to gather all necessary information. Furthermore, to meet this duty, boards often are advised to establish a basis of comparison across transaction options in order to be able to defend the fairness of the transaction's terms and conditions.

The Duty of Obedience to the Charitable Mission

Lastly, the duty of obedience to the charitable mission (which is acknowledged in a majority of states) requires that a director further the charitable purposes of the corporation and act in conformity with all laws generally affecting the corporation. To fulfill this duty, directors should have a strong understanding of the charitable purposes of the organization. It is incumbent upon boards to constantly examine their mission and purpose, and to understand how a consolidation might further (or detract from) that mission. In order to provide effective oversight, the board must understand the rationale prompting a specific proposal, and how that proposal supports the organization's objectives.

In examining any consolidation transaction, the general counsel or outside counsel should brief the board on the standards of conduct the law will expect it to apply in connection with its evaluation of a consolidation proposal. A consolidation transaction will require the board to apply a higher level of attentiveness and scrutiny to its review than it does to normal and customary board matters. If the board

elects to delegate day-to-day oversight of the consideration and negotiation of a transaction to a standing or special committee, the extent of that delegation, and the communication between the committee and the full board, should be thoroughly understood.

Advance Establishment of Good Governance Structures

Establishing good governance structures and the authority of the board is critical to achieving a positive outcome in a consolidation transaction. Furthermore, hospital and health system boards should take this action well in advance of the actual consideration of a consolidation opportunity.

State law uniformly agrees that the board is in charge and that no consolidation transaction of any consequence can proceed without board approval. The expectation is that management and its advisors will do the basic "blocking and tackling," but that the transaction is the board's responsibility and the board must sign off on the final game plan. This is to ensure the presence of checks and balances deemed necessary to protect charitable assets, given the potential and unavoidable conflict of interest when management team members negotiate with their potential new employer. A prepared board will assess potential approaches to managing the process of a consolidation transaction well in advance. The board should consider establishing a "strategic review committee" or other committee that will be tasked with assessing combination opportunities (both inbound and outbound). While the committee should not take over the full activity of the board, the committee can vet opportunities, gather data and information, and present findings in a coherent fashion to the full board. Consolidation proposals and similar "big deals" require a transaction timetable that is sufficient to allow thorough evaluation. This is an area where the board and the designated committee can exercise particular common sense oversight (e.g., "This is dragging; we need to pick it up," versus, "This timetable is too aggressive; we need to slow it down.")

The board must have an understanding of the proposed transaction

timeline, the implementation of a competitive process, the risk exchange involved in the major decision-making points (e.g., a letter of intent and definitive agreement) and any external factors (e.g., regulatory or principal vendor approvals) that may influence the timetable. Significant mistakes are made when boards do not realize the steps involved, the sequence of those steps or the intentional use of proven processes to maximize outcomes.

Lastly, the board should develop its evaluation criteria in advance of the consideration of a potential consolidation. Such evaluation criteria should include information relating to achievement of charitable goals, the reasonableness of financial terms, human resources issues, implications to the medical staff, and closing responsibilities and obligations. The criteria also should reflect recognition of specific transaction-related legal risks (e.g., antitrust challenges). An increasingly important consideration is the extent to which the board had the opportunity to consider the results of the due diligence investigation and the related risks (regulatory and operational) to the organization. This is especially the case if unusual or unexpected risks are identified. The presence of a written record reflecting application of such criteria will be very persuasive to regulators called upon to review the transaction and the board's related diligence.

Key Issues for Board Consideration

As the overseer and steward of the non-profit hospital or health system's assets and charitable mission, the board should be aware of key issues that it will be asked to confront when considering a consolidation transaction.

At a minimum, issues include the following:

1. **Know your state regulators and their power**

   Consolidation transactions are frequently governed by various laws that are overseen by a State Attorney General office (charitable and antitrust sections). There also may be Certificate of Need filing requirements. A board should be aware in advance of the applicable regulators that would review and provide input on any

consolidation transactions.

2. Be prepared to defend the decision

The board should be prepared to answer central questions that external critics likely will pose, including: "how did the board arrive at a particular decision?" and "what steps did it take to ensure that the transaction value and terms are fair?" The best defense against these questions is the rigor and thoroughness of a well-run, board-led process.

3. Understand your corporate structure

The differing corporate forms of hospitals and health systems and consolidation transactions are important to understand. For example, in change-of-membership-based arrangements, it is important to articulate with clarity such important governance-related terms as the formation, mission and board composition of the parent organization; the specific reserved powers to be retained by the parent over the affiliate hospital providers; the process by which board members and chief executive officers are selected and removed; and any special voting arrangements, such as supermajority provisions. In arrangements involving faith-based organizations, it is important to establish a process by which particular faith tenets and identities are preserved and protected.

4. Be prepared to handle federal antitrust matters

Depending on the size and structure of the proposed consolidation transaction, the parties may be required to file a Hart-Scott-Rodino (HSR) application with the Federal Trade Commission (FTC) and the U.S. Department of Justice (DOJ). The HSR application requires that the parties disclose materials that discuss the proposed transaction and the service area. The general counsel and/or outside counsel should advise the board regarding the creation and content of written communications, which can create unintended issues and delays with the FTC and DOJ. Regardless of whether an HSR application is required, the FTC and DOJ continue to challenge transactions in the health industry that they view as anticompetitive. If the FTC believes the proposed consolidation transaction is potentially

anticompetitive, it typically contacts payors for their input on the proposed transaction. Hospital leadership may positively influence payor reaction by identifying the community benefit and procompetitive effects of the transaction and communicating those benefits to payors and the community. Demonstrating the transaction's value to the community is also part of the board's Duty of Obedience discussed before.

Conclusions

It is vitally important that management (including general counsel or outside counsel) make a special effort at the beginning of the transaction process to brief the board on the law's expectations and how the management team can support board compliance with those expectations. This should be neither a difficult nor cumbersome task. The failure to complete it, however, will jeopardize the likelihood of a successful transaction and the reputation of the board.

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The Board's Role in the M&A Process: Meeting Fiduciary Obligations

By Michael Peregrine and David Gordon

Chances are that most non-profit hospital boards will be called upon to evaluate a merger/acquisition proposal at some point in the very near future. Healthcare reform is prompting hospitals across the country to reevaluate their market strength and competitive posture given the new regulatory dynamic. Local healthcare markets are increasingly fluid, as providers and physician groups are anxiously wondering whether there will be a chair remaining when the reform-styled music stops playing. Alignment with a complementary provider — whether as partner, seller, or buyer - may be the favored strategic option. Whether, and under what terms and conditions, the provider pursues such alignment ultimately should be the board's decision.

For that reason, it is increasingly critical that executive management properly prepare the board to evaluate an M&A opportunity in a timely and informed manner, consistent with its fiduciary duty. Questions to ask include: What is our role? What should we be looking at? How involved are we to be? State law expects the board to closely oversee the transaction process in order to preserve the value of the corporate assets and protect the charitable mission. Absent management-directed preparation, however, will increase the odds of a fiduciary misstep. This, in turn, will weaken the credibility of the board's ultimate decision and imperil any board-endorsed deal's chances for regulatory approval.

Experience suggests the following topics as forming the core of the board's M&A preparation: **It's really your call.** State law is uniform on this point - no M&A deal of any consequence can proceed without board approval. The expectation is that management and its advisors will do the basic "blocking and tackling;' but that the board must sign off on the final game plan. This is to assure the presence of checks and balances deemed necessary to protect charitable assets.

Problems will arise when the board is uncertain or unaware of its fundamental transaction authority.

The "why" of the deal. In order to provide effective oversight, the board must understand the rationale prompting a specific proposal. Is it *offensive* (e.g., the opportunity to expand services into a new market)? *Defensive* (e.g., blocking a competitor from increasing its strategic position)? *Practical* (e.g., the need for a stronger capital base and economies of scale from which to respond to reform initiatives)? *Problems will arise when the board is not familiar with the mission and business realities that recommend the transaction, or if it has unrealistic expectations (or predisposed notions) about transaction rationale.*

Any simpler options? In its consideration of any major transaction, the board will be expected to ask whether the intended goals can be achieved in a less intrusive, or expensive manner. That's an essential element of oversight-calling the question. "Is there a simpler way to do this". Regulatory approval may well depend on evidence of such analysis (e.g., "Well looked at 'A,' we tried 'B,' we ran the numbers on 'C,' and none serve the mission as well as the deal on the table right now."). The board will need to exercise particular scrutiny if the hospital seeks to pursue the first change-of-control offer it has ever received (i.e., if the hospital seeks to "marry" the only organization it has ever "dated"). *Problems may arise if the record does not reflect board consideration of alternative approaches to achieving the acknowledged goals.*

The source of the matter. The board should be familiar with the source of the specific M&A proposal; what is its history and how did it come to be presented to the organization? For example, is it prompted by unusual circumstances? Is it an unsolicited offer or the product of specific negotiations or bid process? Does it reflect the vision of the executive leadership team, a prominent board member, the entire governance team, or an influential third party? Is the proposal specific in its terms and benefits, or is it vague or uncertain? *Problems may arise if the proposal reflects uninformed pressure from community groups, or "social blackmail" (e.g., leading constituents threaten to abandon the hospital absent "this deal").*

Establish the standard of review. The general counsel should brief the board on the standards of conduct the law will expect it to apply in connection with its evaluation of the proposal. This will likely require the board to apply a higher level of attentiveness and scrutiny to its review than it does to normal and customary board matters. If the board elects to delegate day-to-day oversight of the consideration and negotiation of a transaction to a standing or special committee, the extent of that delegation, and the communication between the committee and the full board should be carefully understood. *Problems will arise if, when called upon to approve fundamental transaction decisions, the board does not find itself sufficiently involved or informed.*

No conflicts. The board must be vigorous in the application of its conflict-of-interest policy to the consideration of the transaction proposal. Reliance on the results of the annual disclosure process simply won't do; there must be a transaction-specific conflicts disclosure and review process. The law is extraordinarily concerned that biases of individual officers and directors not unduly affect the board's decision- making process. Effective disclosure will target not only relationships between board members and the prospective partner organization (and its fiduciaries), but also relationships between board members and the organization's advisors, as well as relationships those advisors may have with the target organization. *Problems will arise if arguably conflicted directors (or advisors) participated in the board's discussion of, and vote on, the transaction.*

What's the timetable? M&A proposals and similar "big deals" require a transaction timetable that is sufficient to allow thorough evaluation. The board must have an understanding of the proposed deal timetable, the length of time allocated for negotiation, the projected closing date, and any external factors (e.g., regulatory or principal vendor approvals) that may influence the timetable. Specific items requiring full board vote should be flagged and scheduled. The board (and in particular, the negotiating committee) must work closely with management to balance legitimate time exigencies with the need for appropriate board involvement and awareness. *Problems will arise if the board cannot digest*

key transaction information fast enough to keep pace with transaction events or if director attendance at key board meetings is sporadic.

Information review and reliance. Management should clarify for board members the specific documents and other information they will be required to review in connection with their oversight responsibilities. This relates not only to definitive transaction documents, but also to reports and summaries provided by management and outside experts. Different standards may apply to the negotiation committee and to the full board, especially if the expectation is that the board will be relying on the oversight activities of that committee. However, there should be some fundamental expectation that the full board will have reviewed a detailed definitive agreement summary prepared by counsel, even if it has deferred to the negotiation committee the review of the draft and final versions of that agreement. The board should also have an understanding of the extent to which it must rely on the Judgement and recommendations of management, board committees, and outside advisors. *Problems may arise if neither the board nor the negotiating committee has at least reviewed a thorough summary of the definitive agreement.*

Evaluation criteria. One of the management's most important transaction responsibilities is to provide the board with the specific criteria by which it can evaluate the benefits of the transaction and render an informed decision. Such evaluation criteria should include information relating to achievement of mission goals, the reasonableness of financial terms, human resources issues, implications to the medical staff, and closing responsibilities and obligations. It should also reflect recognition of specific transaction-related legal risks (e.g., antitrust challenges). An increasingly important consideration is the extent to which the board had the opportunity to consider the results of the due diligence investigation and the related risks (regulatory and operational) to the organization. This is especially the case if unusual or unexpected risks are identified. The presence of a written record reflecting application of such criteria will be very persuasive to regulators called upon to review the transaction, and the board's related diligence. *Problems may arise if the record does not reflect a coherent and relevant board evaluation process.*

It's their call. Each board member should understand that the basic standard they should apply in determining how to vote is whether he/she reasonably believes that the transaction as they understand it is in the best interest of the organization. There is no obligation to vote in a manner consistent with management's recommendation, but a decision to vote in a contrarian manner should be one that is informed, rather than emotional. They should ask themselves whether the transaction they are voting on is essentially the same transaction that was first brought to the board or whether it has evolved through negotiation to something different – and whether the reasons for that shift are understood by the board. In addition, the board must be capable of resisting the pressure to vote on way or another based upon the prevailing transaction momentum, whether it be positive or negative. *Problems will arise if the board is perceived as simply "rubber stamping" management's plan.*

Rare is the hospital or health system that will not be considering a merger/acquisition opportunity in the near term, either for offensive or defensive reasons. State and federal regulators will closely review these transactions, especially those in which non-profit assets are to pass from non-profit to for-profit ownership. Central to that review will be the extent of informed, disinterested oversight exercised by the governing boards of parties.

Therefore, it is vitally important that management (including the general counsel) make a special effort at the beginning of the transaction process to brief the board on the law's expectations and how the management team can support board compliance with those expectations. This should be neither a difficult nor cumbersome task. Certainly, failure to do so will jeopardize not only the likelihood for a successful transaction, but also the personal reputations of board members.

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The Strategic Alignment Committee: A Ready Response to Reform

By Michael Peregrine and David Gordon

Hospital boards are encouraged to form a "strategic alignment" or similar committee to facilitate the governing board's ability to evaluate the many business opportunities that will arise for provider organizations in the wake of seismic health reform legislation. The expectation is that the entire spectrum of healthcare organizations--not just hospitals and health systems, but also insurers, specialty facilities, medical groups, and physician networks--are actively considering both vertical and horizontal relationships of varied sorts in order to better position themselves to respond to health reform-prompted economic opportunities. In such a unique environment, it is incumbent upon the hospital board to shed its reputation for inertia and assert a proactive response to such unique opportunities. The purpose of the strategic alignment committee is to evaluate, on behalf of the board, business proposals and risks early in the opportunity cycle--as opposed to condemning them to the queue of the normal board agenda. The expectation is that the work of this committee will favorably position the full board to respond quickly and in an informed manner to meaningful alignment opportunities.

What's at Stake

It should be no surprise to the hospital board that reform legislation has dramatically accelerated thoughts of consolidation across all aspects of the healthcare sector. As the healthcare financing system shifts from traditional fee-for-service arrangements to "bundled" or "value-based" payment models, market participants are scrambling for proper positioning, identifying those structures most likely to enhance financial viability. Competing institutions are now evaluating the benefits of consolidation. Stand-alone hospitals are considering linkage with larger systems. Regional systems are reviewing potential synergies with national systems. Fiercely independent physician groups are revisiting employment or other forms of affiliation with local healthcare systems. Parties that hitherto would never have

spoken to each other are now actively engaged in alignment discussions. In all of this "scene-shifting," there is an element of urgency. For example, the hospital's ability to provide "accountable care" and ultimately be classified as an "accountable care organization" (ACO) may well depend upon the performance of basic assessment, planning, and implementation steps in the very near term. In addition, many hospitals, health systems, and academic medical centers are actively considering merger/acquisition/affiliation opportunities of varying degrees of integration, both with other providers and with practitioner groups as well. Many healthcare markets are becoming highly fluid, as individual market participants position themselves to pursue opportunities or confront threats. The pursuit of certain opportunities by a hospital's competitors may foreclose similar opportunities for the hospital itself. Things are happening fast; there are many moving (corporate) pieces. In this context, the non-profit hospital's traditional governance style of slow, careful, and sometimes ponderous consideration of strategic matters becomes more of a burden than a virtue. The competitive marketplace is actively being reshaped in "real time," placing a premium on a streamlined board-level deliberative process. Enter the strategic alignment committee.

The Committee Concept

The Scope. The purpose of the strategic alignment committee is relatively simple--to conduct the "spade work" on alignment opportunities for the board. This means that the committee's responsibility is to "roll up its (collective) sleeves" and perform core-level market monitoring, the parsing of speculative developments and the evaluation and prioritization of legitimate opportunities. Executive staff would direct market information and incipient-level opportunity development to the committee for consideration. While it would periodically report to the board on its activities and on its perceptions/observations, the committee would refrain from coming before the board in any significant way until a major opportunity presents itself. At that point, the committee would present an evaluation of the opportunity based upon the due diligence and goals analysis it has been conducting on a regular basis. In this way, the committee operates in a contemporaneous yet supplemental position to the regular board

process, allowing critical market evaluation and alignment-focused strategic planning to proceed, independent of the normal board agenda.

The Tasks. The duties of the strategic alignment committee generally include the development of protocols and processes that will enable the board to aggressively address legitimate business opportunities as they are deemed to arise. This may logically include tasks such as: (a) developing specific mission-based goals and objectives for strategic alignment; (b) crafting business development screens; (c) preparing marketing presentations to various potential alignment partners; (d) establishing opportunity evaluation tools, *e.g.*, operational, financial, reimbursement, mission, and legal; (e) considering multiple, alternative acquisition/merger/joint venture/affiliation models; (f) formalizing and standardizing board approval processes and procedures to facilitate prompt decision making; (g) constructing frameworks for due diligence processes depending upon the type of opportunity presented; (h) conducting critical "market intelligence" with the help of professional advisors; (i) periodically interfacing with bond insurers, lenders, external auditors and other interested third parties/hospital constituents as may be necessary; (j) anticipate specific enterprise risks arising from alignment activities; and (k) monitoring legal, regulatory and legislative developments affecting health reform in general and alignment opportunities in particular. On a more targeted basis, it could serve as the principal board-level interface with the multiple levels of planning and activity necessary to position the hospital to implement an "accountable care organization".

It will be important, though, to carefully craft the charter of the committee to clarify the distinctions between the tasks assigned to this body and other standing or special board committees with responsibility for strategic planning, physician relations, enterprise risk management and/or transaction planning.

Status. The question is whether the strategic alignment committee should be "standing" (*i.e.*, permanent) or "special" in status. There is no "hard-and-fast" rule here. The argument in favor of "special"

status is that the committee is not expected to be permanent in nature; the potential alignments which the committee is likely to consider are probably going to arise within the next several years, as the various participants in the healthcare sector can be expected to complete their game of (corporate) musical chairs. The argument in favor of "standing" status is that the Committee's activities, while limited, are nevertheless likely to last several years, and elevating the committee to the same status as that of more traditional bodies, such as the executive, finance and audit committees, is likely to increase its governance-level prestige. The committee should also be granted board-designated powers with respect to the limited scope of its charter, because a primary goal of the committee is to gain efficiencies by enabling the board to rely on its due diligence with respect to reform-prompted business opportunities. The board would not, however, be delegating to the committee the right to actually proceed to negotiate or commit the organization to specific opportunities; that, of course, would remain the province of the board.

***Membership*.** The committee need not be exceptionally large in size, but must include independent board members with a particular affinity for strategic planning, and who have a strong grasp of healthcare reform and the challenges and opportunities it creates. Selecting members who may also serve on key committees like executive, finance, medical staff relations, and/or audit will help facilitate coordinated committee and board-level planning. Should state law allow it, the committee might logically include non-board members with strategic skills and medical staff representatives. That notwithstanding, the board should be very sensitive to the potential conflict-of-interest risks associated with involving physician leadership in a board committee that will have some jurisdiction for reviewing physician integration and similar types of transactions affecting physician practices and business investments. The committee must have heavy staff support, from both the executive leadership team (including the CEO, the CFO and the general counsel) and outside advisors, including strategic consultants and investment bankers.

An Example

The intended operation of the strategic alignment committee can be demonstrated through the following example. A regional, multi-hospital integrated health system ("Regional System") has enjoyed steady growth over the last several years, and has successfully integrated a recent affiliation with a community hospital. Its area competitors include two other community hospitals (one of which is affiliated with a national, religious-sponsored system), an affiliate of a statewide non-profit system, and a division of a large proprietary hospital chain. Regional System management is closely watching developments in the marketplace, as the various participants begin to consider collaboration or similar strategic opportunities. In addition, Regional System is interested in structuring its controlled group practice organization as an ACO. The status of the market is highly fluid, and aggressive action by one or more of its competitors may foreclose some opportunities to Regional System and re-prioritize others. Management's concern is that the board, with its agenda full of major operational issues, may not be well-positioned to evaluate and react to emerging opportunities in a timely manner. In this context, the role of the strategic alignment committee would be twofold: (a) to assist management in taking the initial steps towards the establishment of an ACO; and (b) to work closely with executive leadership to establish strategic alignment goals for the board's consideration, to monitor market developments and to evaluate the core feasibility of multiple different business options that may arise. The expectation is that these efforts will greatly facilitate the ability of the board to make informed judgements concerning alignment opportunities in a competitive timeframe.

Advantages and Disadvantages

The Advantages. The strategic alignment committee achieves critical efficiencies by allowing fundamental strategic alignment planning to proceed independent of the normal and customary agenda of the board and of its key committees. It establishes the necessary deliberative infrastructure critical to eventual board-level evaluation of legitimate strategic opportunities without the need to fit within the

queue of the normal board process and structure. It conducts the "heavy lifting" that enables the board to move quickly to evaluate and consider only the most logical and feasible of business/integrations opportunities.

The Disadvantages. The strategic alignment committee will, by necessity, add to the workload of both executive leadership and the volunteer board members called to serve the committee. The administrative cost of the committee will be higher than most because of the likely need to seek the involvement of outside advisors on a regular basis. There is a potential that the duties of the committee will overlap, or conflict, with traditional standing committees of the board that have viewed their charter as including strategic and transactional planning and enterprise risk management. Further, there is a risk that, because of the important activities assigned to the committee, it may act as somewhat of a shadow board, potentially pushing the envelope of its assigned authority.

These advantages and disadvantages must be carefully considered by the board. Yet, the prudent decision may well be to create some committee-level function responsible for monitoring strategic alignment opportunities and vetting their initial feasibility. In the current fluid healthcare sector, the hospital board and its decision-making process would benefit greatly from any committee support mechanism dedicated to conducting initial feasibility analyses of reform-prompted alignment opportunities.

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Non-Profit Boards and the Merger Market: Preparation, Organization and Approach Part I

By James Burgdorfer

There has been a dramatic increase in the need for non-profit organizations to consider macroeconomic industry conditions and the resultant role of the merger market. Hospital and health system boards of directors must be proactive and take into account their business and financial circumstances in relationship to this phenomenon. This article explores the industry dynamics that have contributed to this trend and notes an emerging view that may contribute to future merger transactions.

Economic Setting

There are multiple economic factors altering the structure of the hospital industry. This structural change and its underlying causes—including industry consolidation and shift in ownership—is not well understood, and driven by these factors:

- Even before the shock of COVID-19, nearly half of non-profit hospital companies were experiencing some form of financial difficulty, often accompanied by a decline in debt ratings and diminished access to capital
- The capital markets' response to the hospital industry's circumstance has been polarized:
  - Access to debt markets has become more difficult due to concerns about the credit characteristics of borrowers
- Historically low interest rates and low spreads have masked underlying performance issues
  - Well-capitalized non-profit hospital systems have been seeking to secure their futures through targeted transactions involving the merger market

Defense versus Offense

Nearly all sale transactions completed by non-profit hospitals since the late 1990s were based on defensive considerations. With the prospect of and then passage of the Affordable Care Act, we saw more offensive transactions. Ultimately, both defensive and offensive consolidation results from the difficulty associated with governing entities in an extraordinarily fragmented industry.

It can be difficult to anticipate and respond to operating and financial problems and trends. It is even more challenging to identify problems resulting from the larger changes to the structure of the healthcare industry. It often takes years of financial difficulty before boards are willing to consider the merger market. Indeed, non-profit boards' responses to financial problems follow a discernible pattern:

- Focus on operating and financial problems happens only after violations of financial covenants occur
- Operating consultants are then retained, usually resulting in expense reduction and a refocused organization.
- Non-core assets are frequently sold
- A decision to close or sell the hospital might be made
- During this process, mission and "value" usually dissipate

However, important changes are occurring in board decision making at certain health systems, as some of the most foresighted non-profits have become concerned about industry changes. The following developments are responsible for this new approach:

- The IRS, Congress, and state attorneys general are challenging non-profit status, executive salaries and property tax exemptions
    - Structural change and business complexity are causing boards to consider the need for larger operating scale
    - There is increased emphasis on physicians' ability to participate in economics through joint ventures

As a result, boards of leading organizations are becoming proactive. Boards can and should use the merger market as an offensive tool to ensure their system's future success.

Future Board Action

We encourage boards to recognize structural change and other macroeconomic trends, and proactively consider the merger market in their planning. Ideally, decisions regarding operating and ownership alternatives should be based upon an organized understanding of a hospital's business circumstance and changes to the structure of the industry. Depending on the situation, this could be considered in either of two contexts:

- If a health system is experiencing poor financial results, including
- Lack of access to capital, the board should determine whether the fundamental issue is operational or systemic. If systemic, early consideration might be given to a sale or merger
- If a system has experienced strong financial results, the board might consider the likelihood of continued success given changes to the structure of the industry. Potentially, it might consider whether the merger market could be used to forestall future problems such as insufficient scale

Historically, non-profit hospitals and health systems have focused on operating and other microeconomic issues and have considered the merger market only after experiencing financial trouble for several years. As a result, mission and value are often eroded. Today, however, the boards of some of the most successful systems are carefully considering the impact of fundamental changes in the structure of the hospital industry and are becoming more offensive in their thinking about the merger market. We suggest that boards consider the merger market in a proactive way, regardless of their circumstance.

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Non-Profit Boards and the Merger Market: Preparation, Organization, & Approach Part II

By James Burgdorfer

Two Views: For-profit vs. Non-profit

Few, if any, large industries have two major groups with such widely divergent views and approaches to the merger market as the hospital industry. For-profit and non-profit systems approach change-of-control dynamics and transactions in entirely different ways. For-profits view the merger market as an ongoing component of their business; non-profits often approach it in an *ad hoc* manner. This latter view can compromise mission and business interests of the non-profit. *This is particularly true in the current environment, which favors non-profit buyers.* Historically, non-profit boards have focused on operating and local-market issues. Today, however, many non-profits recognize that they are operating in an industry where:

- Change is occurring to the structure of the industry and the complexity of the business has increased dramatically
- Both for-profit and non-profit companies are participating in this change, but often with different approaches

For-profit companies have had a stronger business case for growth, which has resulted in greater use of the merger market. The difference in perspectives between the two groups is dramatic, but should narrow in the future. Most for-profit companies:

- Seek growth
- Are organized to both create and react to opportunities quickly
- Understand the procedural nuances of transactions
- Have small boards with national representation and perspective

Whereas, most non-profit systems:

- Seek strong credit profiles
- Are often unprepared to address the merger market

- Often lack experience with the procedural nuances of transactions
- Have larger boards consisting of local leaders

Regardless of whether responding to overtures from for-profit suitors or attempting to grow via acquisition or merger, non-profit boards and CEOs would benefit from reconsidering their approach to the merger market. This is particularly true in light of current conditions that favor non-profit buyers—the credit market crisis and operating environment have caused many for-profits to temporarily reduce their growth objectives.

Outcomes

The merger market holds two meaningful outcomes for non-profit systems—growth of the business and mission, and outright sale and alteration of the mission:

Growth: strong non-profits are currently seeking to secure their futures by developing greater business scale. Much of this growth will, by necessity, result from merger market transactions in the form of acquisitions or mergers. In so doing, these non-profits will often be confronted with competition from for-profit purchasers of hospitals.

Foundation: this occurs when communities seek to "monetize" their investment in the hospital business. In a *conversion,* or sale to a for-profit, the board is electing to exit hospital ownership and enter the healthcare foundation business. This is often accompanied by an objective of greater capital investment in the hospital. For example, the sale of Mission Health to HCA in 2019 resulted in a commitment of $430 million in capital improvements to the health system and created a sizeable healthcare foundation from the net proceeds of the $1.5bn sale.

Alternatively, affiliations and other non-change-of-control arrangements have less obvious outcomes and a higher rate of failure. These approaches often amount to "feel good" exercises, which consume great amounts of time, result in little benefit, and forestall needed change.

Preparation

Regardless of whether a non-profit system is contemplating growth, a foundation model, or neither, non-profits would be well advised to undertake and document a thoughtful review of their financial and business situation and available strategic financial alternatives—from both a business and legal view. This sort of review has become standard practice for those non-profit systems experiencing financial challenge. Unfortunately, most rarely consider such an effort unless faced with immediate difficulty. As a result, many system boards are consumed with operating detail and local issues, and do not understand the potential impact of external trends on their mission and business.

A comprehensive review of the organization's business, financial, and market circumstance provides a solid basis for developing a meaningful understanding of strategic options—in terms of both operating and ownership alternatives. This sort of approach is central to good decision making and defending against external criticism of any resultant transaction. The review can be done internally or with external assistance. In our experience, every non-profit board should be equipped with knowledge of their value and access to capital, along with an understanding of the impact of structural change, and whether financial challenges are situational or systemic.

Organization

Non-profit systems trail for-profits in being organized to best take advantage of merger market opportunities:

- Management: for-profits typically have a development function with dedicated employees. Non-profits often do not, and most relegate this task to a part-time effort by the CFO. While the need for a development department may vary, it is essential that someone within the organization be held accountable for strategy.
- Boards: non-profit boards are often large and multi-focused. In our experience, it is best to leave most merger market matters to a

standing committee—executive, strategic planning—that reports to the full board. Too often, these are created only to react to events; they should be permanent features with a distinct focus on strategy.

Approach

Non-profit management and boards should adjust their approach to the merger market, particularly when attempting to use it to achieve growth. Part of the challenge is organizational, but a shift in approach is often needed. We would suggest that non-profit boards consider the following:

- When looking to the merger market for growth, accept competitive processes as both a business reality and a necessity for sellers. Occasionally, non-profit management teams and boards eschew participation in competitive for-sale processes, even when the target holds strategic importance. These types of processes have become a necessity for sellers in order to satisfy state attorneys general and other critics.
- Taking a more commercial approach to the merger market is essential for future success. As Juniper manages for-sale processes, we are routinely struck by the difficulty non-profits experience in assembling indications of interest in competitive processes. Often, this is as simple as overcoming a tendency to overanalyze at the beginning. Most competitive process include very adequate time for full due diligence—but later in the transaction. At the outset, much detail can be postponed, without being disingenuous, through the use of contingencies. We also often see a lack of understanding of the steps of a transaction and their interrelationships. Boards would be well advised to review this with outside bankers or counsel.

Current merger market conditions favor non-profit consolidators; this is an opportune time for non-profits to achieve strategic objectives. In order to take advantage of this opportunity, non-profit

boards and management should reorient their approach to the merger market.

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Retaining and Incenting Management

By David Gordon and Jordan Shields

Much has been written about the fiduciary responsibilities of hospital board members that are considering business combinations. Another important issue that has received less attention is leadership continuity throughout the transaction process. Increasingly, there has been harmful senior management and board member turnover during the consideration and pendency of transactions. Hospitals typically have rolling terms for board members, along with employment contracts and policies for their executives. However, these are often inadequate in the context of transactions involving ownership change. The elephant in the room for most boards exploring a transaction concerns only the post-closing impact of the transaction on the executive team.

Juniper has observed the serious disruption that board and management dislocations during the transaction process can have on transaction outcomes. While this is a sensitive topic, failing to address it can diminish value. Management and board turnover has frequently led to lost partnership opportunities, lost vision for the future of local healthcare, lost consistency of organizational objectives, lost time (which is never good for sellers), and, on occasion, millions of dollars in lost consideration.

Background

This topic is increasingly relevant as consolidation pressures mount in the healthcare industry. More hospitals, both independents and systems, are (or will be) considering fundamental decisions regarding their futures. Management teams and boards are actively assessing the likely impact of health reform, including the adequacy of organizational resources to effectively implement ACOs, to respond to market competition and to increase physician interest in employment models. As a result, they are evaluating affiliations, sales, and mergers as tools to be used to meet their organizational needs. Given that these are always substantive and often anxiety-provoking conversations, organizations require management and board leadership

stability to thoughtfully reach consensus on the long-term direction of the organization.

The currently high volume of hospital merger and acquisition activity has not been seen since the 1990s. Then, the emergence of health management organizations drove hospital consolidation as a way of addressing underlying costs. Today, the key factors leading boards to consider business combination transactions center upon:

- An increased need for scale to cope with declining prices and higher costs
- Vertical integration and regional coverage to strengthen contracting and quality
- Access to capital is increasingly dependent on size as a result of the growing sophistication of the municipal bond markets and a "size penalty" imposed on small providers by the rating agencies
- The need to develop "systems of care" as the reimbursement environment shifts from fee-for-service to "fee-for-health"

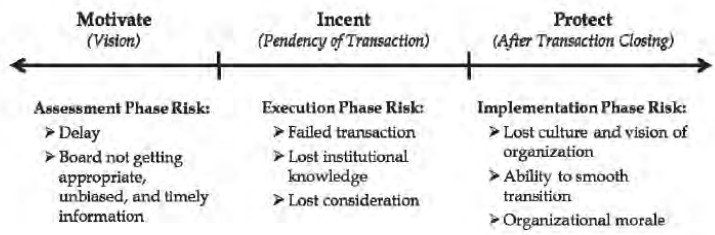
Change-of-control transactions may or may not be the right answer for organizations. They do, however, merit serious consideration as both healthy and struggling organizations face a dynamically altered future for the industry. These sorts of transactions represent a *material professional risk for senior management*. Successful evaluation and execution of transaction opportunities also demands increased attention from both senior management and volunteer boards. For these reasons, it is important for organizations to have the right measures in place to foster a thoughtful and unbiased assessment of how best to secure the long-term provision of quality healthcare in the market.

We have regularly encountered CEOs who have no contractual protections and yet have advised their boards on the need to consider strategic alternatives. It should be noted that they do this based upon an overriding concern for the future of the organization, but at great personal risk. Boards often fail to recognize that the lack of protections for management under these circumstances might result in *de facto* incentives for management teams to avoid transactions. Change-of-control represents both significant additional work for executives over the course of the transaction, and the potential end of their role

with the organization. Contractual protections for executives help relieve management of potential conflicts. Furthermore, financial incentives for senior executives can relieve inherent biases related to the additional effort required of those managers in the event of a transaction. As described below, the costs associated with failing to secure the continuity of organizational leadership throughout the transaction process can have material negative financial and organizational implications. With industry-wide hospital CEO turnover ranging from 14–18 percent per year for the last 20 years, there is a significant risk of management turnover at all times. When this turnover occurs immediately preceding, during, or immediately after the pendency of a transaction, the negative repercussions can be large.

The Importance of Continuity throughout the Transaction Process

The need for management continuity and unbiased, thoughtful input from the board exists throughout the transaction process, and takes on distinct forms within each phase of a transaction. Below, we break transactions into three major segments—assessment, execution, and implementation—and discuss the role of continuity within each.



Assessment Phase: Motivating Management

Before transactions get underway, management wields significant influence over what opportunities organizations consider and how those opportunities are perceived. Without appropriate managerial safeguards, boards are effectively incenting management teams not to consider the full range of strategic options open to their organizations. Managers have the ability to thwart transactions before they

are even considered by not educating their boards, moving slowly when opportunities present themselves, or by subtly steering their organizations away from partnerships. Additionally, if senior managers decide to leave as the board moves toward considering a transaction, they can be hard to replace because it is difficult to hire strong executives to fill positions at organizations considering transactions.

Typical management employment contract terms that boards should be discussing with their advisors:

- Change-of-control payout
- Termination clause
- Retention bonus

For these reasons, boards are encouraged to consider incentives aimed at eliminating unintended biases inherent in standard executive contracts. By including change-of-control payout, termination, and buyout clauses in executive contracts, boards can ensure that the financial disincentives are removed. These encourage executives to bring information forward to the board and allow the board to complete its fiduciary duty and assess its full range of options.

Execution Phase: Incenting Management

From a financial standpoint, the execution phase of a transaction, which includes the period between the hospital going to market and closing the transaction, represents the greatest risk to executive retention. Suitors seek stable organizations and departing executives can damage employee morale, create uneasiness amongst physicians, and become distracted and less likely to anticipate and address competitive threats. Depending on when they occur during the execution phase, departures can also significantly slow down the process, which is generally not good for sellers.

Executive continuity is especially critical during this phase, however, it is a period when executives often feel most vulnerable. While it is routine for suitors to maintain executive leadership, this varies widely and is difficult to enforce unless explicitly included in the

Definitive Agreement, which does not come until late in the transaction. Additionally, recruiters and rival systems are aware of this vulnerability and often increase their courtship of managers at organizations considering transactions.

The impact on value of losing executives is not limited to the CEO. For example, if a CFO departs, the organization can lose an important knowledge base related to significant terms in the transaction (e.g., the calculation of working capital, paid time off and receivable activity). As a result, the organization could potentially miss opportunities to most-effectively negotiate alternative offers and fully represent its value to the market. With the loss of management, organizational history and implicit policies and procedures can also be lost. Even when this knowledge can be recovered, it typically slows the process, creating risk for the seller.

Implementation Phase: Protecting Management

After the transaction closes, management's institutional memory can help ensure a smooth transition to new ownership. They can help maintain the culture and vision of the organization and foster employee and community morale. While retention clauses are generally offered for this phase of the transaction by the acquiring organizations, they are only relevant for executives who have been retained up to this point. If executives expect to be released immediately after closing or have limited confidence in the purchaser to retain their positions, they are at risk of leaving, even when they have execution phase incentives. These execution phase incentives can be "bought out" by recruiters taking advantage of vulnerability before the transaction closes. Therefore, it is important to have safeguards. Ideally, these would be in place before the assessment phase to protect management after a transaction closes so as to incent their retention throughout.

Board Continuity

Like management turnover, board turnover during the transaction can damage the organization. This can occur for a variety of reasons,

including board members deciding to roll off as time demands increase through the transaction process, board members who leave during the normal board cycles, and board members who decide they are not interested in serving in an advisory capacity vs. fiduciary capacity if the role of the board changes post-acquisition.

During the assessment phase, board members— especially board leadership—should apprise themselves of the demands of the transaction process and, if they decide to stay on, commit to remaining in their positions throughout the transaction. This is typically a one-year commitment but can vary depending on individual organizational circumstances.

Continuity of executive and board leadership throughout the transaction process is critical to ensuring effective outcomes and maintaining organizational value. These issues should be discussed openly before organizations begin considering transaction alternatives in order to minimize inherent biases and maximize outcomes. Boards that effectively ensure continuity preserve value and are more likely to make the best long-term decisions for their organizations.

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Three Compensation Structures for a More Successful Transaction

By Jordan Shields, David Gordon and Jeffrey Peterson

Eighty-seven percent of hospitals are considering alignment with another hospital or system as a part of their overall strategic planning, according to Dixon Hughes Goodman. This interest is primarily attributed to structural factors in the industry, including the shifting reimbursement environment and issues related to new healthcare regulations that place independent hospitals at a competitive disadvantage.

The business of governing acute care hospitals and health systems has become increasingly complex. At the same time, there is tremendous opportunity due to the expanding range of strategic alternatives available to independent hospitals. Despite these market realities, many boards have failed to implement protective structures that incentivize senior management to objectively assess opportunities free of personal contractual distractions.

This article reviews the types of safeguards that hospital system boards should have in place to promote senior management objectivity.

Hospital systems should position themselves to evaluate strategic alternatives on their merits without succumbing to the unintended consequences of misplaced management incentives. Boards that recognize these competing factors and structure contracts that promote management objectivity will position their hospital system to make thoughtful decisions for their stakeholders based on board directives — without distraction or misalignment with senior executives.

Properly structured incentives can improve transaction outcomes by promoting continuity before and after a partnership is consummated. By putting these incentives in place, boards promote open communication and trust with management. Trust is always important in the

principal-agent dynamic between management and the board, but it is of particular consequence in transactions where management may feel vulnerable. By putting the right incentives in place early, objectivity is promoted and heat-of-the-moment decisions are avoided.

As more organizations consider strategic alternatives with other systems, we have seen an increase in failed transactions due to unaligned board objectives and management incentives. The effect is magnified when experienced transaction advisers and transaction counsel are not involved at the outset.

These unaligned incentives manifest themselves in a variety of ways. If senior executives are unsure of the impact on their personal situation, they may not fully engage with respect to the board's directive to evaluate strategic alternatives in an ongoing and comprehensive manner. Also, uncertainty causes hospital systems to lose high-performing executives before, during and after the strategic alignment processes, even more so if the transaction is drawn out or delayed. We regularly encounter boards that "didn't know" their full range of alternatives to align with senior management, or boards that wish that they had acted sooner.

We have also had clients who lost key executives before, during and after ownership transitions. Many strategic partners place significant value on a strong leader at a health system. During the transaction process, senior management can motivate team members to move a transaction forward, and they are often best-positioned to engage with the hospital's various constituents, from physicians to community members. After the transaction is complete, they prove invaluable in assisting with transition matters and capturing transaction synergies. The departure of key management members destroys value and hurts healthcare delivery, but the likelihood of this can be minimized through contracts that align board and management interests.

While many management contracts have features to protect executives in a change of control situations, such as severance arrangements, contracts regularly miss key features. The result is a classic

principal-agent problem with management's interests misaligned with the board's objectives. Given the real and perceived risks to top executives in strategic partnerships, it is at least naïve — and possibly unfair to management — for boards to expect senior executives to expose themselves to professional risk without structures in place that mitigate these risks.

Fortunately, boards can take steps to address these issues through employment contract features. In this article, we will explore three key contractual features that organizations should have in place for their top executives to align senior management and the board. These include continuity bonuses, change of control bonuses and integration bonuses. We will also discuss practical considerations in aligning management incentives with board objectives.

Types of Incentives

Continuity Bonus – Continuity bonuses are designed to retain top management during the pendency of a transaction. These are typically paid out at closing (or a brief period, such as 90 days, after the closing). After selecting a strategic alternative and starting down the path with a partner, the loss of a key executive team member can put the arrangement at risk. At worst, the partnership fails pre-closing, and the organization is left without its preferred partner or outcome. In any event, the organization ends up scrambling to consummate the relationship without a key resource. The period between partner identification and the close of a transaction is a particularly challenging time for hospital executives. They are trying to focus on the day-to-day aspects of running a hospital, while at the same time, planning and implementing a due diligence process, navigating relationships with vendors, physicians and employees, and generally driving a transaction toward its consummation. These multiple roles, combined with personal job uncertainty, inevitably leave executives more likely to depart. Organizations can help mitigate the likelihood of their departure through incentives that recognize the additional work and associated risk related to these activities.

Change-of-Control Bonus – A change of control bonus is intended to incentivize senior management to remain with the organization through closing, by ensuring they retain their position or receive a severance package. A change-of-control bonus can have a "single trigger." That is, the change of control itself triggers the right to the bonus. Alternatively, the change of control bonus can be "double trigger," meaning that after the transaction, the executive would need to be terminated or otherwise have a reduction in title or role. These arrangements protect executives from termination by the new owner, a change in relative responsibility, or other issues related to change in employer and role. The result should be an executive who can remain focused on carrying out the board's directive with respect to a strategic transaction, while knowing that thy have a financial "safety net" in the event they are not asked to remain with the organization.

One unintended consequence of poorly written change-of-control bonus language: it can incent executives to leave even when they would prefer to stay on. If the change-of control bonus is triggered, the executive may be faced with a decision between staying on or taking the bonus and leaving. For this reason, boards often buy out change-in-control bonuses at closing with the executives rolling into new employment contracts with the partner. This allows the executives to stay on without having to make the difficult choice of forgoing the bonus.

Integration Bonus – Many boards feel strongly that their executive team, having helped identify their system-partner and guide them through a strategic transition, is best-suited to ensure that the board's objectives are realized in the new relationship. Executives can be encouraged to stay on through the transition period via integration bonuses that recognize the additional work involved in integrating the hospital with its new system partner. The integration bonus can also help balance a shift in responsibility that C-level executives face. An independent hospital CEO, who was accustomed to reporting only to his or her board, faces a significant career adjustment in now also reporting to a system executive and possibly multiple dotted-line supervisors and boards. Similarly, an independent hospital CFO may

no longer handle raising capital or other components of his or her former role. To incent these executives to stay on in their new capacities, boards can offer integration bonuses that vest over time or are based on tangible integration metrics. This feature can incent key executives to stay on through the integration with the new system.

Practical Considerations

While these incentives are all regularly used to align management's interests with those of the board, they have not been universally adopted. There are a variety of reasons for this, but two surface more often than others.

As managers of their community's largest and most complicated businesses, hospital executives can often be among the highest compensated individuals in their communities and board rooms. With respect to non-profit and community hospitals, executives' compensation may be public and well-known. Therefore, even if the alignment of incentives would best serve the hospital and the community it serves, boards may worry about public scrutiny of these arrangements and hesitate to address these issues. The second reason is more nuanced. As outlined above, typical contracts provide a disincentive to management's objectivity. Coupled with the board's natural bias toward maintaining the *status quo*, this can result in myopia in the boardroom, which may result in the organization's failure to objectively assess how to serve best the community's healthcare needs over the long term. When implemented correctly, the compensation structures outlined above do not incent executives to move in favor of a transaction or maintain the *status quo*. These structures will balance the dis-incentives created by typical management contracts and encourage an objective dialogue in the best interests of the hospital's community. Decisions are best made by maximizing the unbiased review of the full range of strategic alternatives. The same reasoning that has led more organizations to actively consider their full range of strategic alternatives supports a fresh review of transaction-related incentives included in management contracts.

These contractual elements are appropriate for a core group of key executives. Boards look to this core group for unbiased advice, and departures at this level are most profound. A rule of thumb is that these objective-leveling incentives should apply to those executives who have employment contracts containing specific severance clauses.

While it is best practice to enter into these "objective-balancing" contracts when hiring or promoting an executive, there is never a bad time for a board to better align management contracts with organizational objectives. It is not uncommon for a board to ask why senior management has not been evaluating strategic alternatives, only to realize this result was an artifact of unrecognized dis-incentives that unintentionally quelled the conversation.

Conclusion

Management and boards want to do the right thing — objectively weigh strategic alternatives to serve best their communities over the long-term. Management contracts that misalign these incentives are often entered into with the best intentions. It is up to boards, management teams and their advisors to regularly evaluate these structures to protect valued executives. Contracts that do not favor one outcome over another ultimately support the evaluation of strategic alternatives on their own merits.

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Parallel Paths to Realignment

By Jordan Shields, James Burgdorfer and Stephen Morrissette

Payment reform poses a seemingly endless list of complex, interrelated questions. For the trustees and executives responsible for guiding their institutions through this unfamiliar terrain, the best answers to those questions often can be found in another industry.

The commercial banking and hospital fields have much in common. Both are service providers in low-margin, capital-intensive, commercially challenging and technologically complex industries that are among the country's most heavily regulated. Their greatest similarity, however, is the central role that each plays in our communities. Both are visible, influential institutions that elicit strong emotional attachment from community members. Additionally, banks and hospitals often share trustees and it is common for bank executives to serve on local hospital boards and for hospital execs to serve on local bank boards.

Despite these commonalities, surprisingly little thought has been given to the parallels between the two industries. Reviewing banking's recent history reveals lessons that can be applied to hospitals.

Patterns of Consolidation

While the commercial banking industry continues to consolidate, it is already significantly more concentrated than the hospital industry. The 10 largest bank holding companies have more than 80 percent of all banking assets. By comparison, the 50 largest hospital systems generate only 25 percent of all hospital industry revenue. By exploring consolidation in the banking industry, we can identify patterns that likely will emerge in the formation of larger hospital companies in the coming decade.

Distressed mergers presage strategic mergers: When banks began to consolidate in earnest in the mid- 1980s, distressed banks were the first to sell. These weaker organizations were losing ground to better-

positioned competitors that were able to make the large investments necessary to modernize their operations and expand.

By the mid-1990s, a shift occurred in the industry. Many distressed banks had sold, but the consolidation trend actually accelerated. Well-positioned banks that had been able to keep up with the capital demands of a changing industry began to recognize that selling or merging represented the best way to improve and expand their platforms. Large, successful organizations increasingly looked for other large, successful organizations with which to merge.

As in the early days of banking consolidation, systems that pursue mergers have been perceived as distressed and needing the resources of a stronger partner. But this perception is changing. Strong, well-positioned organizations with excellent reputations, margins, physician relationships and access to capital are seeking merger opportunities. These organizations recognize the change in the health care environment characterized by commercial and operating complexity and narrow margins.

As with the banking industry, success will be defined by efficiency and the ability to adapt quickly to a new environment. Local companies without scale or regional perspective will have difficulty. Trustees can serve their organizations best by remembering that future success is tied to the provision of high-quality services at competitive rates, not yesterday's independent balance sheet strength.

Consolidation accelerates: Strategic mergers led to larger commercial banking companies, further increasing their strength relative to smaller banks. This manifested itself in several ways, including new information technology platforms like ATMs, lower costs for commodity services and the development of riskier, more-specialized services. Larger financial institutions are better able to absorb fixed IT costs. They are also able to devote more resources to the development of new and complex financial products and risk management techniques.

Commercial banks offer a variety of highly standardized, commodity-like services such as credit card lending and mortgage banking. Larger organizations are able to apply their economies of scale to these commodity business lines to expand market share and increase profits. Banks with larger asset pools can take on more volume from any given customer than can smaller banks without increasing their relative risk profiles. Additionally, larger banks are better positioned to develop customized services without any single product materially impacting the risk profile of the organization. For all these reasons, banks became stronger as they grew, leading to a cycle of consolidation.

A similar trend is emerging in the hospital industry. The operating performance of larger systems is, on average, better than that of smaller ones. In an industry with low operating margins and high fixed costs, this size advantage cannot be overstated. Strong operators have better access to capital, and advantages compound over time. This is playing out as large systems are outpacing their smaller rivals with investments in physician infrastructure, quality improvements and IT.

Despite industry consolidation, room remains for independents: As commercial banks have grown, there have been organizations that have bucked the trend. These banks typically fell into one of three categories:

- those that have entrenched customer bases that have been overlooked by larger organizations;
- those that have structural impediments to merger, for example, credit unions that are willing to trade performance for local control;
- those that have intentionally focused on narrow service lines. These banks may offer a full range of services locally, but are typically national providers of a single, high-margin service.

Industry experts agree that the days are numbered for stand-alone community hospitals offering a full range of acute care services through independent medical staff. However, two types of independent hospitals likely will survive. First, government-owned, safety-net

hospitals that receive local tax support will last. Second, certain strong hospitals in exceptional markets may decide to forego scale efficiencies. These organizations largely will be isolated from competition and will enjoy unique medical staff relationships, philanthropic support and demographic attributes that allow them to survive the shift to value-based contracting.

Local service trumps local control: Despite public angst related to banking consolidation, it has been customer-driven. The reasons are multifaceted. First, while corporate strategy and structure are determined at headquarters, service and relationships are maintained locally. Therefore, day-to-day interactions with banks change little when their headquarters move elsewhere. Second, as the range of financial services offered by commercial banks has grown, customers have sought these services first from institutions with whom they already have relationships. Third, as banking services have evolved, customers increasingly expect robust online banking functionality. Larger banks are better equipped than local banks to invest heavily in their Internet platforms because they can spread these costs over a larger customer base. While the location of a given bank's headquarters is fodder for cocktail conversation, it appears to have an insignificant impact on sustaining and growing customer relationships.

Large companies are generally better able to decentralize authority than stand-alone organizations. For example, banks with limited assets can have a harder time authorizing a large, well-secured loan. Likewise, an independent hospital with inadequate operating rooms or an outdated emergency department may have complete local control but still no ability to adequately fund or quickly approve an attractive capital project. Facilities with the capital and scale to anticipate change and invest in quality outcomes will win the day.

Consolidation Lessons Learned

The experiences of the banking industry hold several possible insights into future hospital consolidation transactions and subsequent integration. The lessons center on standardization, timing and community relationships.

Integration, standardization and centralization: Economies of scale can be realized through standardizing and centralizing activities; this was one of the central tenets of the industrial revolution. Greater standardization can increase quality, improve efficiency and reduce costs.

The banking industry has wrestled with the proper degree of standardization and centralization for the past 30 years. In the hospital industry, numerous experts and research studies have emphasized the significant benefits that result from evidence-based medicine and the increased use of standardized methods and protocols. The Institute of Medicine found that the United States wastes $130 billion per year on inefficiently delivered services that could be eliminated through standardization.

There will continue to be a role for independent and specialized hospitals that are able to offer unique value propositions that large systems can't provide. However, hospitals should carefully consider the experiences of many small banks. At the start of banking consolidation, simply being local was enough to attract depositors as large companies struggled with integration and merger execution was poor. Eventually, large banks improved service, forcing small banks to find other ways to differentiate themselves.

Timing matters: Change in the number and size of companies in a given industry often results from the interplay of three forces: economy of scale, customer preference and regulation. These forces can act as catalysts that reward scale and efficiency and penalize poorly positioned industry participants. Classically, organizations that are affected but cannot adapt to these forces fail to remain independent. To achieve optimal timing, sellers need to consider these forces.

For hospitals facing thin or negative margins, one obvious lesson from the banking industry is to move early rather than late. While executive teams are trained to be optimistic, it is better to sell a slightly stressed operation than to wait to sell until reaching full

financial crisis.

But merging before becoming distressed requires a difficult and candid assessment. The standard for independence should not be survival, but the ability to efficiently offer high-quality services in a changing environment.

External factors are also at play. If either the market demographic or market share declines, value has been lost, regardless of financial circumstance. A healthy institution in a strong market can control its destiny. However, even these institutions must be mindful of their situations. Should their best partner join the hospital across town or shift corporate strategy, even the strongest hospital can find itself eventually merging with a less-than-optimal partner.

Community relations: Because banks and hospitals are important to their communities, emotions regarding mergers and acquisitions often run high. There are many lessons for hospital trustees. First, be prepared for emotional responses, especially from elected officials, and implement reasonable tactics to address these concerns. Even more so than banking, elected officials view hospitals as a quasi-public organization similar to the institutions they control, such as schools, parks and libraries. Professional public relations advice has become a necessity for a hospital that is considering a merger.

Second, patients and physicians ultimately will refocus on what matters most: clinical outcomes and patient service. If a merger improves these two primary factors, these concerns eventually will dissipate. In the end, patients, employees and physicians are most concerned about good health care, not the hospital's name or sponsorship of the local parade.

Unique Circumstances

Hospitals and banks share many commercial, regulatory and social features, and, yet, they find themselves at opposite extremes in terms of company size and industry concentration. The hospital industry's position as the most-fragmented major industry in our economy is

even more paradoxical when compared to commercial banking. With poorer access to capital, fewer diversification opportunities and a less advantageous pricing mechanism than banks, consolidation's appeal to hospitals makes sense. And yet, these anomalies have left many well intended hospital boards clinging to local control without context, true understanding or accountability.

But despite predictions of rapid consolidation in the hospital business, the change likely will occur over many years and in a halting manner. Much value and opportunity for improvement will be lost in the process. Lessons from banking consolidation - timing, standardization and community relations - have tremendous value.

Public Hospitals and Partnerships

By Jordan Shields and Ken Marlow

Hospitals and health systems are facing an array of compounding pressures. Chief among these is a once-in-a-generation shift to population health and value-based care models which require health systems to make information technology, administration and care investments as well as take on additional financial risk. At the same time other challenges abound, including slowing revenue growth, increasing expenses, outright reimbursement cuts, migration from inpatient to outpatient services, yawning pension gaps and others. As a result, all hospitals are examining ways to best position themselves to improve quality, decrease costs, increase scale, improve position relative to vendors, service providers and payors, and become the preferred health system in their regions.

Although these pressures are common to virtually all hospitals and health systems, regardless of ownership or tax status, governmental hospitals oftentimes perceive that these pressures are perhaps more acute for them due to their patient populations, restrictions on capital, complicated governance structures and disclosure requirements. As a result, many public hospitals are actively participating in discussions with prospective partners, whether they be other governmental, 501(c)(3) or investor-owned health systems.

The range of governmental hospitals and partnership options is broad. When we refer to governmental and public hospitals in this article, we include hospitals that have some form of state, city, county, district, hospital authority or public trust involvement. This includes 501(c)(3) organizations that lease their facilities from governmental units, as well as quasi-governmental facilities with lingering public oversight. Related to partnerships involving these organizations, we will discuss certain predominant structures when relevant, but use the terms partnership and combination to include the full array of structural alternatives including leases, asset purchase

agreements, membership substitutions, joint operating agreements and joint ventures. This article tackles key considerations for partnerships involving a public hospital.

The resulting partnerships involving public hospitals include unique governance, political, legal, business and regulatory considerations. These issues are relevant to the boards of all involved as they impact how governmental hospitals can come together with partners. This article explores the unique attributes of public hospitals and the resulting restrictions and non-healthcare responsibilities they face when considering partnerships. Key considerations include: ownership and governance; approvals; Sunshine laws; political considerations; sovereign immunity; and anti-trust protections.

Ownership and Governance

Unlike community 501(c)(3) hospitals which typically have self-perpetuating boards, public hospitals have distinct, identified owners. The state, county, city, district, hospital authority and public trust entities exert their ownership control in different ways. This can include *tight control* – with the governmental entity appointing the hospital board and approving all decisions – to *loose control* – with the governmental entity fairly removed from a semi-autonomous 501(c)(3). Regardless of how they assert their control, the objectives of the governmental entities may differ from those of the public hospital boards.

For state, county and city hospitals, differences include the governmental entity's broad mandates to serve their constituencies beyond healthcare. For example, capital requests from the hospital can be in direct competition with capital requests for roads, public safety, prisons or schools. Also, some governmental authorities may face constraints in accepting covenants that bind the actions of subsequent boards, whether they be service commitments, capital improvement commitments or other specifically negotiated covenants.

Districts, hospital authorities and public trusts have narrower mandates, generally focused on healthcare. However, they do not escape the divergence in objectives faced by their governmental entity cousins. The same tax, service and divergent board priorities surface here as well.

Approvals

Governmental ownership may mean that the hospital board does not have ultimate authority to partner without approval. These approvals can take different forms, including a vote of the Commissioners, a referendum or statutory approval. These approval processes are complex, require a number of coordinated efforts of the parties, may have immunity from liability, and may result in the partner entity absorbing the liability. Working with counsel is important to understand what types of partnerships may trigger what types of approvals, as well as the regulatory, statutory or other approval processes.

As a result of the approval processes and the time it takes to work through those processes, along with the fact that input from constituents may cause further review and negotiation of the definitive agreements, it is not uncommon for the timeline for the transaction to be extended significantly and for the parties to find an increase in the number of issues to resolve. Approvals and timing can be further complicated by Sunshine laws that apply to governmental hospitals. (See next section.) These issues create increased opportunities for the transaction to fail during pendency.

The potential for long timelines is one reason that many governmental hospitals pursue management contracts and leases, even when their internal reviews have found that a membership substitution transaction or outright sale might better meet their objectives. Because management contracts and leases typically trigger fewer approvals than mergers and outright sales, these can be achieved more quickly, lowering the risk of transaction failure.

Sunshine Laws

While regulations vary by state, governmental hospitals often face daunting disclosure requirements, including providing public access to books, records and planning documents; holding most meetings in public; and maintaining open bidding procedures. Further, it is not atypical for competitors to review copies of public hospital strategic plans, sit in on their board meetings and gather all manner of competitive intelligence, potentially anticipating and reacting to public hospital strategies before decisions have been finalized. In a time of rapid change, the competitive and operational overhang of these disclosure requirements adds momentum to combination discussions.

As part of the governmental review process, Sunshine laws can require that the definitive agreement be made available to the public for review and oftentimes comment. This can make for difficult negotiations between the parties when the covenants and commitments are available for public scrutiny, particularly since outside constituents do not have the same responsibilities to the health of the community and hospital that the fiduciaries hold. Disclosure can also make partners less willing to make certain financial and non-financial commitments, as they worry that a public agreement will quickly become their *de facto* starting position for all future partnership negotiations. Boards may wish to seek expert advice to help reduce the impact of disclosure requirements on partnership outcomes.

Political Considerations

Not-for-profit boards focus mainly, if not exclusively, on how partnerships will impact healthcare delivery. The governmental owners of public hospitals, however, balance a wider range of considerations. It is not uncommon for a city to sell its hospital and use the proceeds to buy police cars or build a new high school. Understanding the motivations of the owner – and how to work toward a partnership that meets all parties' needs – is an endeavor that cannot start too early in the process. In addition, health system partners should be aware going into the partnership that the governmental hospital may

have enjoyed certain benefits, like access to tax supported revenue bonds or exemption from certain employment regulations, and that those benefits may go away post-transaction.

Similarly, tax issues can flare up in governmental hospital partnerships. Tax support of public hospitals is not uncommon and has implications for a partner likely to lose this support. Less common are successful public hospitals that transfer earnings back to their governmental owners. Additionally, the prospect of a tax-supported hospital flipping to become a property-tax-paying entity has occasionally resulted in governmental entities advocating for investor-owned buyers.

Other Considerations: Pension, Labor, Unique Protections

In any partnership, the entities will need to review pension, labor and liability issues. Treatment of public hospitals, however, requires special consideration of these topics. Governmental hospitals can enjoy certain protections that traditional not-for-profit hospitals do not. It is important for not-for-profit hospitals to understand these protections upfront – to ensure that their expectations for the partnership are valid.

Like religiously sponsored systems, governmental hospitals are exempt from ERISA requirements. The loss of this exemption when a public hospital joins a system that is subject to ERISA can result in increased pension liabilities over and above what is recorded on the public hospital's balance sheet. Further, if the pension plan is still active, there may be specific steps needed pre-closing beyond meeting the ERISA actuarial funding requirements. Governmental entities also enjoy immunity from certain state and federal employee protections, which may be triggered at closing. Sovereign immunity protects public entities from certain tort claims, including particular medical malpractice actions, thus lowering the cost of insurance.

Other post-closing implications include the statutory inability of many public hospitals to indemnify their partners. Public hospitals

may have immunity from liability, requiring the partner entity to absorb these potential liabilities or insure against them. Not-for-profit boards should seek advice on tail insurance and other protections to shield their organizations from liabilities not previously faced by the governmental partner.

Certain state, county and city hospitals have benefited from their exemptions to the federal anti-trust statutes. While it is important to receive early input from experts regardless of ownership of the partner, the nuances of governmental hospital anti-trust protections and their implications on the partnership deserve the board's special consideration. On the business side, not-for-profit hospitals should also consider the impact of the combination on future growth. These are both examples of the limited areas where governmental ownership can be an asset for the partnership.

Conclusions

When public hospitals and health systems actively engage in discussions with potential partners, it is important to recognize their unique governance, regulatory and political features. Understanding the related issues early in conversations is key, allowing both parties to limit distractions and achieve outcomes that best meet their needs. Education and preparation can help boards avoid costly and time-consuming mistakes.

III. Pricing, Valuation and Non-Financial Considerations

Affiliations: Matching Objectives and Risks

By James Burgdorfer

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) and subsequent shifts in the industry. 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 payor 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 (now Advocate Aurora), the largest multihospital 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 over-reliance 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 phenomenon 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.

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Hospital Merger and Acquisition Transactions: A Focus on Retiring Liabilities

By Rex Burgdorfer, Krist Werling and Megan Rooney

The macro-economic forces spurring industry consolidation and rationalization are weighing heavily on management teams and boards around the United States. There is broad consensus that the fragmented ownership structure of the acute-care industry is, in part, responsible for the ineffectiveness of medical outcomes. The presence of a large number of small hospital companies has contributed to the widely held view that our hospital industry, in aggregate, delivers mediocre quality care at an extremely high cost. For these reasons, hospitals are attempting to form larger enterprises to create scale, expand geographically, manage risk, access capital, contend with the changing regulatory environment, improve operating skill, and to more effectively manage the health of the populations they serve.

Despite these strategic and financial imperatives, completing change-of-control transactions has become increasingly difficult. This is due, in part, to the level of financial liabilities found at many selling institutions. Regardless of transaction structure, satisfying liabilities has become an onerous part of completing merger and acquisition (M&A) transactions for both buyers and sellers. These challenges typically include: (1) retiring funded debt, (2) unwinding interest rate swaps, (3) satisfying defined benefit pension plans, and (4) the cost of tail insurance. Today's historically low interest rate environment is partially to blame for the increased cost and complexity associated with satisfying these obligations at the closing of transactions. This article seeks to clarify these challenges and to provide recommended solutions to them when completing M&A transactions.

1. Retiring Funded Debt

The municipal bond market is the most common form of external capital utilized by non-profit hospital systems. This $3.7tn market is by far the most developed in the world, allowing government entities, schools, utilities, and hospitals to finance their operations and capital expenditures. Investors in these tax-exempt debt instruments are

attracted to the strong credit and tax-advantage characteristics of issues in this market. Despite certain high-profile bankruptcies in the recent years (Detroit, MI; Stockton, CA; Jefferson County, AL; Harrisburg, PA), investors have largely remained confident in this market and have shrugged off the default risk forecast by Meredith Whitney over the last several years. Moody's cites that only 71 of the roughly 17,000 bonds (i.e., 0.4 percent) it has rated since 1960 have defaulted. This compares favorably to the 1.5 percent default rate in the corporate bond market.

This investor confidence can be observed in the reduced spreads that A-rated municipal bonds trade compared to AAA-rated Treasuries.

Historically, retail clients were the primary investor base for municipal bonds. However, the proliferation of mutual funds and exchange-traded products has increased the role of institutional buyers. Most underwriters believe this trend will instill more selection discipline and require larger offerings. In turn, this could stimulate the formation of larger, vertically integrated healthcare companies.

While complex in execution, there are conceptually only two broad ways that funded debt (whether municipal bonds, directly placed bank notes, or private placements with institutions) can be handled in a merger or acquisition. Typically, the transaction structure determines the approach.

Purchase of Stock

In a transaction structured as a purchase of stock (as opposed to assets, see below), the target's legal entity remains intact and the buyer "steps into the shoes" of the seller and becomes liable for its financial obligations, including its funded debt. Liabilities of the new subsidiary either remain in place by being assumed or guaranteed by the new parent company (as part of the obligated group), or are retired via refinancing. This form of merger, in which both legal participants survive, usually occurs between two non-profit systems. These are referred to as "membership" or "sponsor" substitutions since there are no clear equity holders in community non-profits. Note, this is not

the case with for-profit, religious sponsored, or publicly owned hospitals that have clearly defined shareholders. CVS's acquisition of Aetna represents a corporate analogy to these member substitutions. CVS, as the new owner, became explicitly liable for the debt obligations of Aetna, assuming around $8bn of debt, upon acquiring Aetna's stock. The same principle is true in the hospital industry.

Purchase of Assets

In a transaction where the acquiror purchases the assets of the target, the buyer is obtaining ownership of select assets and requires that the seller delivers the business "free and clear of encumbrances" at the closing. Asset sale transactions typically occur between non-profit hospital sellers and for-profit buyers and are referred to as "conversions" by regulators because the tax status is changing. In these situations, the seller collects a purchase price from the buyer, retains cash and other financial assets, and utilizes the economic outcome of the transaction (the "gross proceeds") to call, defease, or tender for the bonds. The IRS requires the retirement of tax exempt debt in a conversion because for-profit companies cannot hold tax-exempt debt.

Calling bonds from investors (usually at par) is straightforward and follows a prescribed formula laid out in the bond indenture. Defeasing the bonds is more complicated and necessary when the bonds are in the "no-call period," typically six to 10 years following issuance. Defeasance involves purchasing a laddered portfolio of U.S. Treasury securities that will generate a yield sufficient to pay the bonds' principal and interest payments until the no-call period has elapsed and the bonds can be retired. Defeasance has become more costly recently due to the low interest rate environment.

Tendering for the bonds is rare and involves
negotiating with institutional holders to accept a price less than par. In our experience, this is achievable only during major economic disruptions or in response to the threat of bankruptcy proceedings. For example, in fall 2008, following the collapse of Lehman Brothers, fear motivated some investors to exit securities at less than par. In today's environment, it is difficult to achieve agreement among bondholders for a tender because reinvestment opportunities in replacement securities with a similar yield are limited.

From these two examples, it is easy to see that selling the stock of a business has certain advantages to sellers related to simplifying the handling of funded debt in a transaction. Conversely, buyers prefer to acquire assets as it limits future legal obligations they must become responsible for.

2. Unwinding Interest Rate Swaps

Interest rate swaps are derivative contracts that synthetically convert an issuer's interest payment to either a fixed or floating rate. Non-profit hospital systems have utilized interest rate swaps to a dramatic extent following the market exuberance of the mid-2000s.

Critics of the bulge bracket investment banking business might attribute this trend to declining underwriting spreads on municipal issues. The average spread in 1986 was $12.92 per $1,000 bond; in 2012, the average was $5.52. Swaps, then, can serve as an additional, high-margin financial product for the sales force.

Trading desks formerly arranged interest rate swaps on an agency basis between two client companies with opposing needs (e.g., an insurance company hedging duration risk that sought a floating rate and a manufacturer that sought cash flow stability from a fixed rate). However, banks now trade more on a principal basis and act as the counterparty. Floating rate payments are pegged to major worldwide benchmarks (e.g., SOFR, LIBOR or SIFMA) and fluctuate with those indices. Having entered into fixed-to-floating contracts, many hospital systems are now confronting a scenario where their speculation is significantly "out of the money."

Similar to the discussion regarding bonds in part one, interest rate swaps must be terminated in an asset sale transaction to achieve the "free and clear" requirement of the buyer. Commonly, the face value of the bonds is the notional amount on which the interest rate is swapped. To unwind, a broker will price then cost to terminate the swap with the counterparty. OTC swap market volume exceeded $6.9tn in April 2019, up from $2.7tn in April 2016, so these are products tend to be quite liquid and easy to exit, albeit for a cash payment out of the transaction proceeds.

3. Satisfying Defined Benefit Pension Plans

Moody's Investors Service reports that approximately 72 percent of the 460 not-for-profit hospitals that it rates offer defined benefit plans to their employees (referred to herein as "pension plans"). According to Standard and Poor's, the median funded status of defined benefit plans for hospitals was 85% in 2018, up from 72.6 percent in 2011. If a pension plan is significantly underfunded, that is to say that the benefit obligations under the pension plan exceed the assets held in trust used to settle the accrued benefits, the pension plan represents a concern both from a liability and cash flow perspective. Following the implementation of the Pension Protection Act, a pension plan that is 60 percent or less funded is considered "severely at risk," and a pension plan funded between 60 percent and 80 percent is considered "at risk".

Underfunded pension plans present an issue when negotiating change-of-control transactions. In a stock or membership substitution transaction, the affiliating party may adjust its other commitments to the hospital in light of such liability (underfunding can have a negative credit impact on the entities going forward). In an asset sale, the buyer will likely exclude the underfunded pension plan from the transaction so that it is not legally obligated to maintain or fund the pension plan following the closing. This will require the seller to either maintain the underfunded pension plan, or alternatively, fully fund and terminate the underfunded pension plan (which in most cases is prohibitively expensive).

4. Acquiring Tail Insurance

The operation of a hospital leads to a large number of potential liabilities in the form of medical malpractice claims. A buyer of a hospital will have significant concern that it is not inheriting all of the historical and potential medical malpractice liabilities incurred by the target. Therefore, most buyers will require that a target obtain an insurance policy (or an endorsement to an existing policy) that provides coverage for past known and unknown medical malpractice claims. This type of policy is commonly known as a "tail insurance" policy.

The cost and structure of a tail insurance policy can vary widely. One of the key influencing factors on the cost of such a policy is the cost of errors and omissions insurance in the state in which the hospital operates. If a hospital that is being acquired maintains its own captive malpractice insurance or is "self-insured," it may complicate the approach to tail insurance and there will be a need to purchase tail insurance for the captive's reinsurer. Finally, different features of the tail insurance policy itself (such as whether the policy includes demand or incident triggers) can influence its cost.

The cost of tail insurance and the arranging for coverage for historical malpractice liabilities is an important consideration on a potential transaction.

Conclusion

Some basic arithmetic illustrates how these four issues have caused problems for independent hospitals determining whether they can afford to sell. Consider a $150 million revenue stand-alone 501(c)(3) hospital with $50 million in cash and equivalents. Due to changing industry demands inherent in healthcare reform, this hospital implemented a competitive process to find a partner. The hospital received competing proposals and, for sound fiduciary reasons, has decided to sell to a for-profit company. The for-profit partner is willing to pay the hospital $100 million in cash at closing for the equity of the business. Combined with its $50 million of retained financial assets, the hospital now has $150 million to work with to address these four liability issues. If we assume the following: 1) the cost to defease the bonds is $80 million, 2) out of the money interest rate swaps requires $10 million, 3) fully funding and freezing the pension with the PBGC will require $50 million, and 4) tail insurance is $5 million — this totals $145 million. So $150 million of gross proceeds less $145 million in expenses (before any transaction costs) narrowly nets a $5 million foundation. Many sellers are now in this type of predicament where the strategic logic of a transaction is enormous, but the ability to sell and margin for error is extremely thin.

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As Hospital Deals Evolve So Does Regulatory Scrutiny

By Rex Burgdorfer and Alexandra Normington

Regulators at the state and national levels are reviewing hospital transactions of all kinds with increasing scrutiny. In years past, outright change-of-control deals and for-profit conversions were of primary focus. Today, as unique—and looser—forms of affiliation proliferate, and non-profit systems become more acquisitive, authorities are compelled to take a closer look at these transactions. As a result, hospital Boards and executives seeking a partner for their organization should engage in a carefully designed and comprehensive process to satisfy all regulatory requirements.

The transfer and control of assets is the crux of nearly every hospital transaction. In a membership substitution, control is clear-cut. However, structures like joint ventures and joint operating agreements can be murkier. There are many other models for partnerships with a range of organizational oversight and day-to-day management terms but no formal change in asset transfer, board composition or new entity formation. Such partnerships often seemed to fall outside of the FTC's threshold for reporting under the Hart-Scott-Rodino (HSR) Act.

To address the perceived (by the FTC) underreporting of non-profit hospital combinations, the FTC issued new guidance in 2018 on how to analyze transactions between non-profit hospitals for reportability.

In plain language, the FTC broadened the types of partnerships that are reportable under HSR beyond textbook change-of-control deals to include any shift in who makes decisions for the affiliating hospital. Thresholds for the size of the parties and size of the transactions remain the same, however. When determining if HSR notification is required, ask: Has the corporate member of the affiliating hospital changed? Does a new entity or persons have the authority to approve bylaws or governance documents, executive leadership

appointments, the hospital's strategic plan, contracts or budgets? Can a new party sell hospital assets or incur expenditures on its behalf? If the answer is yes to any of the above, the FTC will likely want a say.

During the COVID-19 pandemic, the FTC did make allowances for closer collaboration between hospitals and health systems but was clear that a pandemic was not the time to skirt regulatory requirements; they made plain that any change-of-control efforts would still be rigorously reviewed.

State Attorneys General have also taken more active roles in hospital mergers and acquisitions. AGs from coast to coast have recently worked to block sizeable mergers (with varied success) while others have placed extraordinary conditions on transactions. AGs continue to be interested in reviewing the growing number of cross-border transactions that may result in control of local charitable assets moving to another state. Among other things, they will look to ensure that the same or a greater level of community benefits will be provided post-transaction.

The increased activity among county-owned health systems as acquirers has also caused heartburn among some AGs who find themselves without jurisdiction over a local government transaction. To clarify any question of oversight, California's legislature introduced a bill that would provide the AG with exceptionally expanded authority to approve or deny proposed healthcare deals over $1 million in value. It is expected that AGs will exert and enhance their authority in healthcare transactions as the scale becomes larger, new parties get involved and multiple jurisdictions are implicated.

As local and federal regulators to put forth increasingly stringent regulatory guidance, hospital leaders should be prepared to demonstrate the rigor and discipline of their transaction process, including documenting the potential partners approached and the Board's objectives and benefits of partnership.

Hospitals can confidently work with regulators on approval of their transaction provided that they have adhered to appropriate decision-making principles, achieved fair terms, demonstrated thorough due diligence, and developed an arrangement that is in the best interests of the communities served.

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Responding to the HIT imperative: A Guide for Independent Hospitals

By Rex Burgdorfer and Jeff Simnick

Independent hospitals and small health systems face a daunting challenge in developing their healthcare IT capabilities to meet the requirements of value-based care. But they must carefully weigh their options and proceed cautiously in meeting that challenge.

Back in 2008, only 9 percent of acute care hospitals had adopted an electronic health record (EHR) that could provide such basic functionality as the ability to view patients' medications or test results. By 2013, this number increased to 59 percent. Today that number is 97% according to available government statistics.

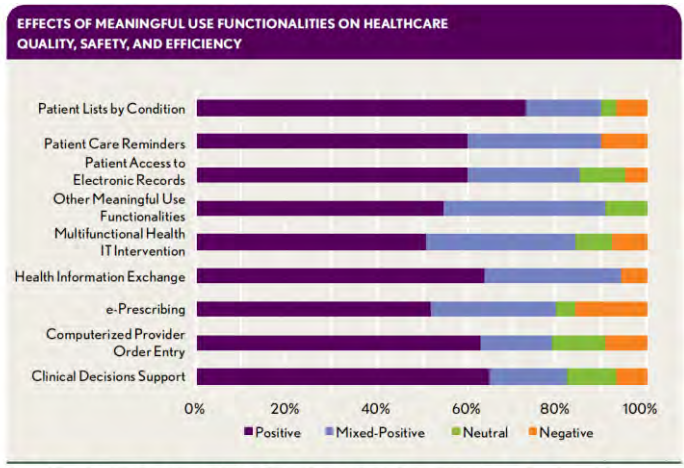
Congress prompted this growth in technological investment by passing two important pieces of legislation: the Health Information Technology for Economics and Clinical Health (HITECH) Act, in 2009, and the Affordable Care Act (ACA) of 2010. The HITECH Act created incentives for hospitals and health systems to adopt EHRs, while the ACA set in motion the U.S. healthcare system's gradual shift in focus from fee-for-service to population health management and value-based payment—a transition that could be accomplished only through the use of sophisticated health IT (HIT) systems.

Experts agree that upgrading the nation's HIT systems will bring communities tremendous health benefits and is the necessary next step for health care as an industry. Michael Alkire, COO of Charlotte, N.C.-based Premier, Inc., has aptly expressed this point: "Investments in HIT, data analytics, and modern clinical infrastructure are foundational for providers to seamlessly deliver population health services".

The findings of a literature review by the Office of the National Coordinator for Health IT identified a prevailing sentiment among authors of HIT focused content that the most common IT functionalities will have a positive effect on healthcare quality, safety, and medical efficiency. The clear consensus is that any hospital still lagging in EHR adoption must

modernize to be able to continue delivering high-quality health care to its community. Driven by government regulation, technological advances, and market competition, traditional inpatient-focused acute care hospitals now view IT as critical to the future success of their business. IT systems are needed for population health analytics, meaningful use requirements, value-based care initiatives, ICD-10 implementation, accountable care organizations' requirements, narrow network navigation, consumer-driven health care, and shifting local market dynamics.

However, such modernization, as with all change, must be approached carefully, and the challenges are more acute for some organizations than for others. Around the country, smaller health systems and independent community hospitals that are struggling to transition to the new IT reality—particularly those organizations with less than $1bn in revenue—are arriving at a difficult conclusion: Given the requirements of the ACA and the HITECH Act hospitals require a comprehensive EHR to connect all components of their system, but the costs of implementing such a system independently are prohibitive.

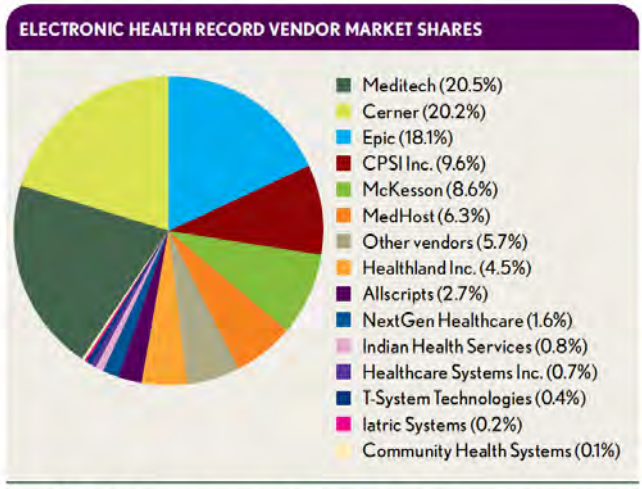


Source: Office of National Coordinator of Health IT, "Effects of Meaningful Use Functionalities on Health Care Quality, Safety and Efficiency, by Author Sentiment (% of Studies): Systematic Review of Literature from 2007-2013," HealthIT.gov, 2013.

EHRs are costly regardless of the choice of vendor, with a full implementation potentially running into the tens or hundreds of millions of dollars. Runaway budgets are common, and the fixed costs (such as initial hardware and software purchases) and variable costs (such as implementation

and training fees) associated with an EHR implementation can quickly grow beyond management's expectations.

As an example of how damaging budget overruns can become, one Midwestern hospital spent millions of dollars and several months of staff commitment upgrading its EHR to a top-of-the line system. After these heavy investments, the system failed to launch properly, resulting in months of revenue cycle disruption, increased bad debts, and decreased government payment, which greatly exacerbated the hospital's financial troubles. Another example is the now infamous IT installation at the University of Arizona Health Network, where budget overruns on the vendor's installation led to unprecedented losses for the system. The health system was saved through an acquisition by Banner Health, which promptly replaced the HIT system.



Source: Office of the National Coordinator for Health Information Technology, "Electronic Health Record Vendors Reported by Hospitals Participating in the CMS EHR Incentive," March 2015.

Adapting to Change

Meanwhile, independent hospitals and small health systems that cannot afford to implement their own EHRs continue to fall behind. To meet this challenge, many small hospitals and health systems are creating a host of new, innovative, but also often not fully understood solutions. Some are

electing to partner with systems that have the capital and expertise to facilitate an EHR rollout. Indeed, the increasingly vital role IT systems play in a hospital's business operations has been a significant factor driving much of the hospital merger-and-acquisition (M&A) activity occurring across the industry in recent years.

Often, however, in lieu of pursuing full business combinations (e.g., joint venture, merger, or sale), independent hospitals and small health systems have sought IT-focused partnerships with large regional or national health systems that rent their platforms and expertise to the smaller independents. As an example, one fairly large southeastern system (with about $700m in revenue) recently partnered with a larger regional competitor (with $2.7bn in revenue) in exchange for a 20 percent cost break on its IT system. Theoretically, such arrangements are a mutually beneficial exchange of cash for services. In practice, however, these partnerships expose the smaller system to unintended risk factors due to asymmetries in the partnership.

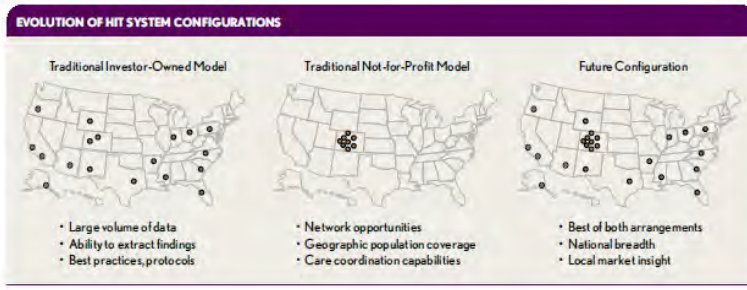
Problems arise in such IT partnerships because one party is providing the other with a fundamental operational need that cannot otherwise be acquired. Whoever is in control of a hospital's IT system will have an outsized role in defining that organization's future. Critics might suggest that this fact is the underlying motivation for larger hospital systems in lending their IT systems to smaller providers: The partnership is not simply an exchange of goods for services, but an opportunity for the large system to get its hooks into a future acquisition target.

In short, although a business combination can be an effective means for an independent hospital to upgrade its HIT capabilities, such organizations should be wary of potential pitfalls associated with such a strategy resulting from unanticipated changes to ownership, control, and governance. Before pursuing mergers or affiliations for such a purpose, independent hospitals should understand their vulnerabilities with respect to such transactions as well as the full range of alternative options available to them, which includes unique partnerships that have been developed by some organizations. Independent hospitals also should conduct a thorough assessment of the full implications of a HIT-driven strategy,

including how a large health system tends to deal with a smaller player's IT system.

Benefits of Scale

It would be myopic to view the IT transition only from the perspective of a small player. The HER transition is disrupting the strategy and decision making of large players as well. For example, in a recent conversation, the CIO of one hospital system with more than $2bn in revenue told us: "Appropriately rationalizing hospital IT is vital in the face of declining reimbursement, increasing compliance concerns, increasing regulation, and an aging population. The main attributes we seek in an EHR program are reliability, consistency, and the ability to create analytical insights." These considerations play a key role in this hospital system's overall strategy, and its executive leadership is fully aware that, given current interoperability standards, having disparate IT systems in a large health system is a burden. The solutions are either to maintain a Gordian knot of an operating system that pulls data from several individual systems, or to migrate all the system's hospitals to a single EHR. Such considerations also are playing into how major systems view targets, deals, and future strategic moves.



The results of these strategies will have an impact on the future configuration of larger health systems. Traditionally, investor-owned companies have been more likely than not-for-profit health systems to have geographically disparate hospitals in highly varied markets with the goal of achieving benefits from diversification. Not-for-profits, meanwhile, have typically owned hospital facilities densely clustered in one region. Experts believe that future success for hospital systems will depend on having

hospitals both densely clustered in specific regions and widely distributed nationally.

To transition to this new distribution model, many growth-oriented large health systems are competing in an IT arms race to partner with smaller hospitals, using what could be characterized as a "bear hug" approach. In this structure, the smaller hospital enters into an IT-sharing agreement and ultimately becomes part of the larger system in exchange for little or no economic consideration or market provisions that are customary for a merger or acquisition. In essence, a bear hug approach amounts to a slow giveaway on the part of the acquired hospital.

Historically, this approach typically would occur between two not-for-profit hospitals, where a independent hospital would be offered the opportunity to "join the family" of the larger system, but would receive no consideration for its enterprise (which could amount to hundreds of millions of dollars).[e] The troubling aspect of such IT-focused partnerships is that the independent hospital, more often than not, is not interested in a full acquisition when it enters the initial IT partnership and is unaware of the larger health system's long-term intentions.

Alternatives for Independent Organizations

Practically speaking, once an independent hospital has agreed to use the IT platform of a larger hospital system, it has, in essence, chosen to become part of the larger system. This is because the arrangement involves an extreme operational reliance on the larger partner that both thwarts any other parties' strategic interest and makes the smaller hospital's prospect of withdrawal from the partnership (or, to use the colloquial expression, unscrambling the egg) untenable.

For this reason, smaller hospitals around the country have begun proactively pursuing innovative strategies to acquire the IT benefits of a large system while maintaining their independence and avoiding a large system's bear hug. These efforts often involve complex arrangements among several determined and committed players to find IT solutions via nontraditional channels. A common approach involves the establishment of a health information exchange whereby several hospitals share healthcare

data to meet their IT goals while maintaining their independence. The sustainability of such exchanges remains to be seen. Along with all the usual IT implementation obstacles, shared information exchanges run into interoperability issues and the stress of balancing the interests of the collaboration's various parties.

Connecticut is home to another nontraditional solution. There, a group of several health systems — Griffin Hospital, St. Vincent's Medical Center, Lawrence and Memorial Health System, Western Connecticut Health Network, and Middlesex Hospital—have entered a partnership to centralize and distribute their healthcare data. The goal of the alliance is to acquire needed big data analytics, while each health system is able to maintain its independence. Thus far, the alliance has proved to be a strong example of how independents can thrive in a data-heavy, population-health-based world. In this way, by creating a constellation of independent hospitals that each capitalize a central data utility shared among the hospitals, smaller organizations may be able to successfully transition to a value-based care environment supported by big data analytics.

Key Considerations for Hospital Executives

In many ways, the future of the U.S. healthcare system remains unclear. But one thing is certain: IT systems will only increase in importance. Future HIT systems will need to be able to collect large amounts of reliable data that can be turned into actionable goals, but getting there will be a capital- and labor-intensive process. With that in mind, the following are five practical recommendations for leadership teams of independent hospitals that want to take control of their organizations' IT transitions based on the experiences of organizations that have effectively met this challenge.

Review the full range of options. All too often in the fragmented not-for-profit hospital industry, management teams and boards do not fully educate themselves on their full range of strategic alternatives. Reviewing what others have done, looking at the benefits and limitations inherent in their outcomes, can be very helpful. More often than not, the comparable situations of other hospitals around the country can inform leadership's decision making.

Be realistic and acknowledge the importance of strong management. Hospital executives should take into account both the strengths and limitations of their organizations' data analytics capabilities, recognizing that an IT system is only as good as the capacity of the local management team. An IT system can lead to improved outcomes only to the extent that the management team is able to interpret information, extract findings, and act on those statistics. Such expertise generally requires a sizable and experienced team. Even if capital is available and the business logic is sound, organizations often find themselves overwhelmed by a product's complexity or dramatically underutilizing its functionality.

Adhere to a budget

Organizations that decide to go it alone in upgrading their IT systems should plan for the worst possible outcome and take steps to make sure they will be able to survive it. Multiple scenarios should be stress-tested and backup plans developed for situations where initial plans go awry. It may be prudent to have hard budgets that cannot be extended, even if it means abandoning an implementation or conversion. Training staff on a new system alone can run into millions of dollars. A runaway EHR implementation can be significantly more costly than the perceived advantages.

Reach out to independent peers. Odds are that within or near every healthcare market there are a number of hospitals that share similar IT concerns. As long as they can find common ground, it's possible for these like-minded, independent hospitals to work together and achieve their IT goals. Several alliances have sprouted up nationally to foster collaborative work among independent hospitals. Shades of gray exist, however, with the forms and structures of these affiliation arrangements and with the degree to which ownership or control, or both, are exchanged.

Be wary of competitors' offers to help. In today's M&A-hungry healthcare landscape, it pays to be cautious. For any hospital looking to avoid a bear hug by acquisitive systems, any offer to integrate IT systems should be viewed with heightened awareness. More often than not, these arrangements end in full consolidation, and it is wise to keep this point in mind while giving full consideration to other options.

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IV. Structural Alternatives

The Expanding Range of Strategic Alternatives Available in Hospital System Mergers and Acquisitions

By Rex Burgdorfer and Jordan Shields

The business of governing acute care health systems has become increasingly complex in recent years as board governance and industry structure have worked to keep up with the pace of reform and consolidation. The sector has evolved from a largely charitable function to a major industry that comprises 5 percent of the gross domestic product. The acute care health system business is capital intensive, highly regulated and technology driven.

Some industry observers point to the level of ownership fragmentation as a challenge to managing and improving the efficiency of acute care services in the United States. The hospital industry is composed of very small companies compared to similarly sized sectors of the economy. In other industries like managed care, airlines, auto and food, beverage and tobacco companies, for example, the 50 largest companies hold market shares in excess of 75 percent.

The 10 largest hospital companies together command around 20 percent market share. The hospital industry has no companies that have full access to capital like major manufacturing companies have—e.g., commercial paper markets, equity markets, debt markets, synthetic markets, foreign listings, etc.

The passage of the Affordable Care Act and other macroeconomic initiatives are designed, in part, to stimulate the creation of larger health care companies that can deliver higher quality, more cost-effective care. Meaningful consolidation will be challenging and take time. Of the roughly 4,500 total acute care hospitals in the United States, there are more than 2,000 "companies" delivering care. With such fractured ownership, population health as well as standardized, efficient, consistent and coordinated care has been an elusive goal. Boards around the country are grappling with these issues and evaluating business

combination opportunities more than ever before. Most boards receive a significant volume of input on the general trend of consolidation, but less input on the full range of strategic alternatives that exist and the processes and tactics that can realize the board's desired outcome— typically the long-term security of high-quality, efficient care across a range of desired services for the community. Tragically, as we have seen with the Covid-19 pandemic, this fragmented, local, and "independent" approach to hospital system configuration also led to ill-prepared supply chains and emergency response protocols.

Significant innovation has occurred in the variety of structures hospitals and health care systems are using to work together. The focus of this article is to describe the structures hospital systems are utilizing in change of ownership transactions, with a focus on the new types of "hybrid" structures that are emerging. These structures include:

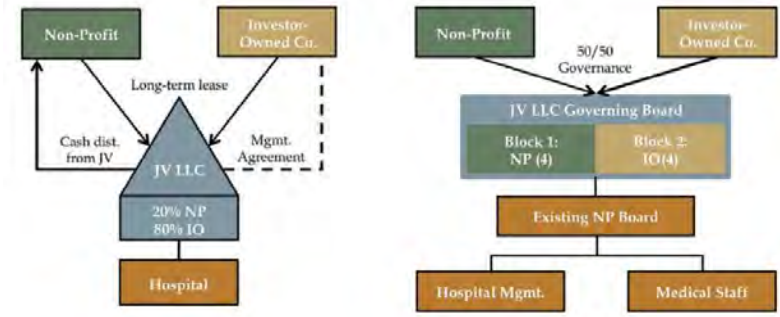
- Seller joint ventures
- Buyer joint ventures
- Multi-party joint ventures
- Minority joint ventures
- Consolidation transactions
- Membership substitutions
- Asset sales

Seller joint ventures - - are typically formed between a community hospital and an investor-owned company, although not-for-profit systems are increasingly offering them as an alternative structure to membership substitutions. The investor-owned company acquires a majority interest in the hospital (usually 60 percent to 80 percent), however, local control is preserved for the community via 50 percent block voting on the joint venture board. Unusual to seller joint ventures, the percentage of ownership does not typically follow control.

Two requirements for a seller joint venture to work are that the selling board must: (1) have a modest level of financial leverage such that selling a 60 percent to 80 percent share of the business is sufficient to retire 100 percent of the liabilities, and (2) have modest future capital needs, as the selling party will be responsible to fund their pro-rata

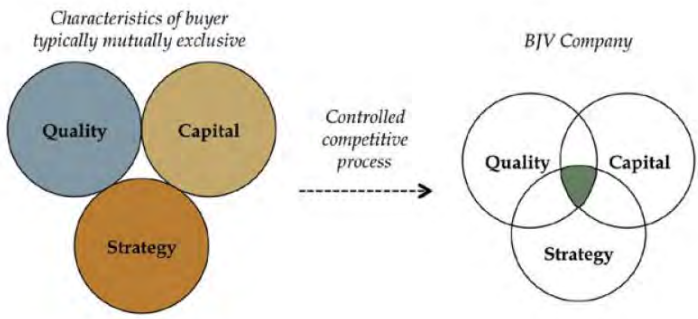
share (20 percent to 40 percent) of capital investments. For example, a hospital that has a large amount of debt in the capital structure and/or a large underfunded defined benefit pension plan may not extract enough proceeds in an 80/20 transaction to fully fund its liabilities at close. Similarly, if a hospital requires significant capital expenditures (e.g., a new patient tower), the resulting foundation may not have enough money left over to prudently co-invest 20 percent in the project. If the local foundation does not have the funds to finance their *pro rata* share of capital calls, it can be diluted. Typically, if ownership falls below 20 percent, the block vote is lost, which tarnishes the original intent of the structure (see exhibit 1).

Exhibit 1: Seller Joint Venture Structure



Buyer joint ventures - - combine the respective expertise of a clinical partner and an equity-sponsored system. The clinical partner holds a minority of the equity interest (typically 3 percent to 20 percent) and is responsible for overseeing medical safety and quality. The investor-owned partner provides capital (typically 80 percent to 97 percent), operating skill and management capabilities to run the community hospital. These partnerships have been very successful and appealing in recent years. Many consider this one of the more important developments in the hospital industry in the last several decades. Selling boards often view these as "the best of both worlds," accessing scale and community hospital management expertise while also including a partner with a strong reputation for and focus on quality.

Exhibit 2: Buyer Joint Venture Structure



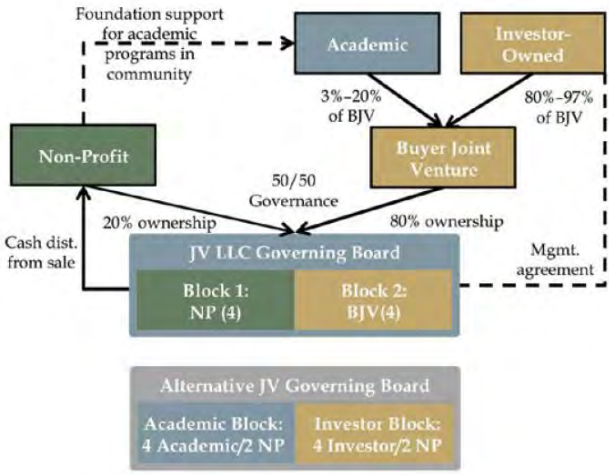
Multi-party joint ventures - - combine the characteristics of the previous two structures, a seller plus a buyer joint venture. This model enables the involvement of a clinical partner, capital infusion and preservation of local control. While complex in execution, it has been implemented in a handful of settings around the United States.

Multi-party joint ventures lend themselves to an emerging, but yet-to-be-realized, development in the non-profit hospital industry: the integrated foundation model. This structure allows community hospitals to utilize the financial proceeds of change-of-control transactions to support research, education, training and other academic functions in a community hospital setting. The promise of access to a share of the annual earnings of the foundation created through the transaction are used to lure a preferred academic partner committed to research, academics, quality and clinical growth at the community hospital.

Historically, foundations that resulted from hospital transactions were limited in their missions. Foundations that resulted from sales to investor-owned systems could not directly support their legacy hospitals because these were now for-profit entities. Conversely, sales to non-profit partners did not typically generate material foundations. The Integrated Foundation Model presents an alternative, allowing the local community hospital partner to utilize the financial proceeds of change-of-control transactions to support research,

education, training, and other meaningful healthcare functions in a community hospital setting (see **Exhibit 3**)

Exhibit 3: Integrated Foundation Model Structure



The MPJV structure is designed to protect the non-profit tax status of the local and academic partners, while leveraging the capital structure of the investor-owned partner. In this model, a well-capitalized hospital enters into an MPJV with an academic medical center or strong regional system and an investor-owned partner. The local hospital retains meaningful local control, as described in the SJV model above. The larger non-profit and investor-owned partners bring the benefits described in the BJV model above. The local hospital releases proceeds from the resulting community foundation to the academic partner to be used for specific, local activities. Unlike traditional foundations that precluded any connection between the foundation and the hospital, here the use of the foundation proceeds is inherently consistent with the mission of the local hospital board and academic partner.

Besides the governance, operating, clinical, and quality benefits of this model, there are real advantages in the use of the foundation proceeds. First, the promise of access to foundation funds to put to work in a community setting can attract non-profit partners that would

otherwise not be interested. Second, distinct joint clinical programs can be funded with the non-profit partner that might not be viable without foundation resources. Third, if one party to the joint venture is an academic, the opportunity exists to establish a significant academic programmatic outpost at the community hospital and align local physicians, possibly through collaborative programs and academic appointments, where desired.

The MPJV model is an example of a structure in which partial ownership (usually 60–80 percent) changes and governance is shared. Depending on the members, the local hospital typically retains a 50 percent governing block or meaningful board representation on both the voting blocks of the non-profit and investor-owned partners.

Multi-party joint ventures are complex structures that offer a range of benefits. They appeal to sellers that are looking for both the material role in governance that is present in the SJV and the balance between academic and investor-owned partners present in the BJV.

Minority joint ventures -- occur where a buyer will acquire a small stake in its target, typically 5–25 percent before issuing a tender offer for the rest. Nibble strategies are pursued because they place the buyers in "can't lose" positions—they either acquire the whole company without having paid a control premium for their upfront investment or they sell their initial position back to the target at a greenmail premium or to another buyer at a premium. In the hospital industry, MJVs are typically entered into between two non-profit organizations. In these joint ventures, the seller retains majority ownership, selling a minority stake to a well-regarded, regional non-profit system.

Motivations for sellers include meeting near-term capital needs, which can be realized through the partial sale; recognition of the benefits of consolidation coupled with political demands for ongoing local control; and desire for a deeper partnership than a transitory "affiliation" or management agreement. Like corporate nibblers, non-profit buyers are typically motivated by the opportunity to fully lock

in an asset without having to pay full value. While the acquisition premium may not apply, the ability to lock up a target for 5–25 percent of full consideration is always attractive. Similarly, sellers often cede rights of first refusal and other valuable deal terms to nibblers. Some buyers also welcome the ability to acquire a blocking interest in a target without having to consolidate it onto the balance sheet.

It is important to note that while MJVs have a somewhat lower failure rate than soft affiliations and management contracts, they are susceptible to the shifting objectives of the partners. These are fragile arrangements that often meet near-term needs without securing long-term market stability or efficiencies. Unlike the other structures outlined here, instability is inherent in the structure as the controlling partner, the seller, lacks the ability to effectively pull through efficiencies from the larger buyer.

The nibble strategy results in a partial change of ownership (typically 5–25 percent) and small change in control. Often the nibbler requires the seller to enter into a management agreement, resulting in an effective shift in control. This structure can be appealing to boards that have hurdles in pursuing a transaction that includes a more significant change in ownership. It is most often seen where the organization recognizes that a partnership is inevitable, but where near-term political obstacles make a small change in ownership more appealing than a larger change in ownership, even when that trade-off results in significant value being left behind.

Consolidation transactions - - occur when two parties combine to create a new parent company with a self-perpetuating board. This was a popular structure in the 1990s and has seen a revival following the Affordable Care Act. Consolidation transactions created many of the larger national 501(c)(3) systems including Advocate in Chicago, Banner in Phoenix and Beaumont in Detroit. Consolidation transactions are difficult to execute. To work, they require two health systems that share a common vision and are similarly sized. It is not unusual for consolidation transaction discussions to unravel over near-term concerns like the identity of the new company's board chair or

chief executive officer. Although tricky to complete, when implemented, consolidation transactions have proven to be the genesis of very successful hospital systems.

Depending on the relative size and strength of the combining systems, ownership and control typically follow one another and are shared based on the economic contribution. It is common for similarly sized hospital systems to consolidate and share control in the newly combined entity, 50/50. Consolidations are typically pursued by organizations that are able to think beyond their existing boards and balance the needs of their legacy organizations with the needs of the newly combined system. For this reason, they require a very high level of cultural affinity and shared vision.

Membership substitutions - - are the most common structures between merging non-profit hospital systems. This structure is analogous to a stock sale transaction in corporate finance. The seller transfers its ownership to the non-profit acquiror who becomes the new "member." The seller's corporate structure typically remains intact, but ownership and control have shifted to the new parent, which also typically becomes liable for the seller's debts. Membership substitutions have not historically created foundations or included significant economic commitments beyond the assumption of the seller's debt. This has changed, however, and regional non-profit systems are now among the highest bidders in sale processes. In many cases, systems are now crossing state lines for strategic partnerships, which increases the number of viable partners for boards to consider. Membership substitutions also typically involve forward looking capital commitments, where the non-profit acquiror commits to continued investments in the facility and medical staff for an agreed to period post-closing, as well as forward looking operational commitments.

Asset sales - - are common between non-profit sellers and investor-owned acquirors. These are also seen between two non-profit partners, when the acquiring non-profit wishes to protect itself from trailing liabilities or quickly fully integrate the acquired facility into its corporate structure. Asset sales typically involve a purchase price,

with the seller using its cash and the purchase price to retire its liabilities at close, transferring just its assets to the new owner. Any additional assets, once liabilities have been addressed, typically form a community foundation.

Asset sales also typically involve a forward-looking capital commitment, where the buyer commits to continued investments in the facility and medical staff for an agreed-to period post-closing.

Conclusion

Maximizing the outcomes of each of these strategic options requires that board members generally understand the purpose and use of each structure, and the factors that influence feasibility, e.g., use of financial leverage, capital expenditure needs, local political environment, etc. Boards equipped with knowledge of these innovative structures will be better able to contend with an increasingly complex operating environment.

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Evaluating Opportunities for Government-Sponsored Hospitals

By Alexandra Normington and Alex Voss

Government hospitals have been increasingly active in mergers and acquisitions in recent years, particularly as regional markets have further consolidated and investor-owned systems' development streaks have waned. For some government health systems, this means growing their footprint in the municipality they serve. For others, it means assessing their long-term sustainability as a government-sponsored entity. As pressures compound on the healthcare industry, governing bodies and the providers they support will continue to weigh the advantages and drawbacks of government hospitals, taking into consideration factors like those below:

Cost and Quality

Advantage: The local government-sponsored hospital is typically the de facto provider of indigent care. The ability to secure funding to bridge operational losses ensures the hospital is not unduly penalized (i.e. through risk-based contracts, readmission penalties) for caring for vulnerable, un-or under-insured patients with complex medical needs. With governmental dollars and ties, the hospital is also best positioned to spend money on preventative care and population health.

Drawback: The healthcare industry, from physicians to hospitals to payors, is moving from volume to value-based reimbursements. Unconditional government allocations do not incentivize the hospital to cut costs, provide higher quality or be more efficient with resources; the government money can essentially underwrite the hospital's inefficiency.

Funding Sources

Advantage: Most local governments have the authority to levy taxes and may also be able to leverage bond issuances and general revenue funds to support healthcare services. These can be more reliable sources of revenue than reimbursements for patient care services.

Drawback: Unlike schools and public works, taxpayers may not perceive necessity to fund healthcare services, particularly when most hospital peers are operated privately. Dollars allocated to the hospital are always at-risk during tax cuts. Tax support is often most necessary for the hospital during economic downturns, precisely when taxes are most burdensome for citizens and revenues decline. COVID-19 may provide an all too explicit example of this paradox.

Liquidity

Advantage: The ability of a local government to provide an infusion of cash during an economic downturn or emergency protects the viability of the hospital as a critical public resource when it is most needed. This occurred frequently during the COVID-19 pandemic with local governments providing loans and grants while elective surgeries cease.

Drawback: Government funding comes with explicit and/or implicit strings attached that may incumber the hospital's operations. In addition, accessing funds results in moral hazard where the hospital does not save for a rainy day like most private organizations, assuming they will be bailed out as "too essential to fail".

Public Disclosure

Advantage: As a publicly sponsored entity, the hospital is obliged to disclose information about its clinical services and business operations. This serves to inform the community about the hospital's activities and provide oversight for the hospital's public resources.

Drawback: Public disclosure requirements can give the hospital's private competitors (who do not have the same reporting burden)

unfettered access to the hospital's strategic plans and a distinct competitive advantage.

Governance

Advantage: Public funding generally comes with some degree of governmental oversight, giving elected officials and their constituents a unique role in setting the hospital's strategic direction and ensuring the hospital is meeting the health needs of its community.

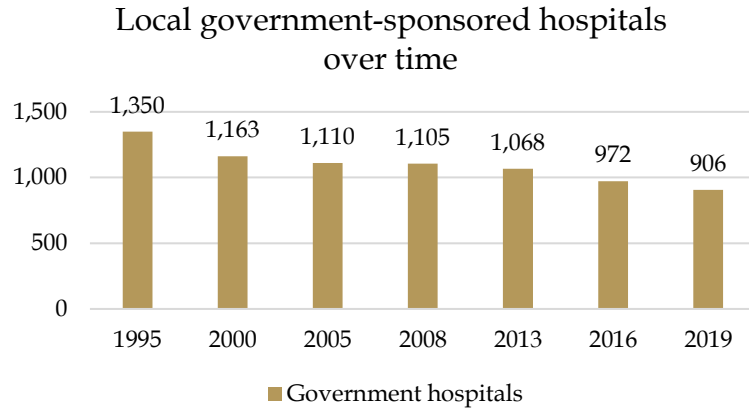
Drawback: Public dollars often come with the requirement that elected officials be a part of (either directly, through appointment or indirect influence) the hospital's governance. The delivery of healthcare and hospital administration are complex and ill-suited to the addition of government bureaucracy.

Mission

Advantage: The government-funded hospital serves as the true local healthcare safety net, providing care to all regardless of ability to pay, and acting as a steward of public health.

Drawback: Non-profit charities can and do often serve the role of providing for those most in need. While some see this as a role for government, many will not see hospital administration as the best utilization of government/taxpayer resources.

In the aggregate, local government hospitals will continue to look to partner with larger private health systems, as illustrated in the following chart. This trend will be accelerated as the COVID-19 pandemic has stretched resources thin and uncovered weaknesses in our nation's health delivery system.



Yet, as challenges persist for hospitals of all ownership types, there will be instances where a government-sponsored system can provide a crucial backstop for a local 501(c)3 hospital. Large public health systems have become increasingly active as acquirers, preserving access to care at community non-profit hospitals that may have otherwise faced service cuts or closure.

Juniper Advisory has helped numerous government-sponsored hospitals consider their positions and opportunities to accomplish their strategic objectives. Each government-sponsored hospital is unique. In some cases, public funding for the hospital truly is necessary to sustain a vital community resource. In other cases, a private partnership may provide benefits beyond what is achievable with modest public funds while also mitigating some of the drawbacks of governmental operation. Evaluating the ongoing viability of a government relationship can be challenging and emotional. However, most optimal outcomes can be achieved when all stakeholders prioritize the health of their communities and sustainability of the hospital above all other objectives.

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Protecting Corporate Value in Affiliation Transactions

By Joseph Cerreta and Jordan Shields

Hospital leaders are increasingly interested in affiliations, or relationships with other healthcare organizations that do not involve ownership changes. Affiliations can take many forms, including management agreements, clinical affiliations, purchasing cooperatives, and joint operating agreements. But they also pose unique risks. Community hospitals often pursue affiliations rather than mergers or outright sales, for instance, to access the benefits of increased scale without ceding ownership. However, this strategy often can result in a shift of control and transfer of the community hospital's ownership without any reciprocal economic or noneconomic benefit. Clear and consistent affiliation objectives— among other strategies—may enable participants to avoid such risks.

Affiliation Drivers

Organizations pursue affiliations to maintain independence while improving qualitative, operational, or financial performance. The objective of affiliations usually is to maximize near-term control while enhancing integration, scale, quality, capital access, or other benefits associated with partnership. Successful affiliations focus on narrow, clearly identified improvements, allowing organizations to maximize the benefits of affiliation while retaining as much control as possible.

As organizations respond to healthcare reform and the shift toward value-based payment models, affiliations can facilitate the exchange of best practices, reduce costs, and provide access to tools necessary for effective population health management. Few independent hospitals cover the full continuum of care necessary to succeed under population management. Achieving full integration through an asset sale or merger, however, often is too large of a leap for board members of many standalone hospitals. Affiliations offer an alternative approach to fill organizational gaps and better position hospitals in the changing payment and operating environment.

Affiliation Risks

Hospital board members often prefer affiliations to other types of partnerships, such as mergers, because they expect affiliations to be easy to implement, unlikely to fail, and protective of local control. However, affiliations involve significant corporate risk and often damage value. The resulting risk and damage has led industry experts to refer to affiliations as "slow-motion giveaways" and "bear hugs." There are numerous examples of community hospitals that have entered into relatively narrow affiliations only to become fully absorbed into their partner within several years. Boards and management teams can account for the inherent risks of affiliations by developing clear objectives before pursuing affiliations as a way to both evaluate risks and formulate mitigating strategies. When analyzing the key goals and tension points likely in a proposed affiliation, the board and executive team should assess the leading risks associated with the affiliation and identify possible strategies to address those risks. The analysis should examine the following areas.

Stability. Unlike mergers, affiliations are not designed as long-term stable structures. Instead, affiliations trade structural stability for maintenance of organizational control, which creates risk. Successful affiliations require ongoing affinity between partners. Although the organizations may have joined the partnership for different reasons, each should derive ongoing benefits, which can evolve over time but are critical to the partnership's success.

Partnership instability is often considered a benefit due to the misunderstanding that it eases dissolution of the arrangement. However, providers frequently find that unwinding an existing affiliation is more costly and harmful to an organization than continuing the relationship on unfavorable terms. Typical agreements include buy-out provisions that are too expensive for the partnership's smaller provider to execute or that leave the junior partner with untenable financial management or operating gaps. Further, because most partnerships are formed among local organizations with shared markets, dissolving an existing relationship can put one partnering organization at greater risk than the other, such as when physician referral patterns

are at stake.

Hospitals that pursue affiliations to solve long-term needs, such as improving their cost structure or branding, face the risk of overreliance on a partner whose interests may change. Smaller partners in affiliations typically risk becoming too reliant on these structures. Then, if either partner decides to exit, the smaller partner is left weakened and worse off financially than it was when it entered the arrangement. Smaller organizations often will surrender to the losing finances of the partnership, or submit to bear hugs, if they find that the organizational cost of exiting the affiliation exceeds the lost value from the slow-motion giveaway.

Realized benefits. Affiliations are designed to promote flexibility and autonomy rather than to maximize outcomes. These relationships, with two separate owners that each have their own agendas, can leave partners arguing over resources and approaches instead of collaborating to optimize care for the community, regardless of the impact to respective bottom lines. For example, partners that share markets may argue over expanding a given service at one location because doing so could reduce volumes at another.

Full integration, which is necessary to maximize the benefits of the partnership and best serve the community, is frequently inhibited by partners that are instead focused on trying to protect their organization. For example, affiliations around purchasing rarely require both partners to standardize their supplies. Instead, partner organizations typically agree on a core set of supplies and then contract separately for others. Although this arrangement is easy to implement and is unlikely to alienate physicians, it also prevents participants from achieving the full savings of a partnership.

Opportunity cost. Hospitals that do not have experience with mergers and acquisitions commonly enter into affiliations without understanding their full range of alternatives. Because partnerships are typically incremental and not episodic, some hospitals pursue affiliations without exploring alternatives or developing a basis of comparison.

For example, a hospital that has identified a need for greater scale, may be tempted to jump immediately to a management contract without any further analysis of options. Although such arrangements allow hospitals to access scale while maintaining local ownership, they also carry an opportunity cost relative to other options. Hospitals that fail to evaluate alternatives, such as a merger, may never know whether another model would have been a better overall business and community decision.

Vetting the range of options available also will promote a better understanding of merits of each option. For instance, management agreements or service-line joint ventures often give the counter party a de facto right of first refusal for purchase. Such provisions are often agreed to without understanding that they can cost the community hundreds of millions of dollars in lost economic value.

Termination. Affiliations are designed to end at some point. The challenge is in knowing how to unwind the affiliation when it no longer meets the needs of both partners. An all-too-common outcome is for the larger organization to absorb the smaller organization at a lower economic and noneconomic sum than the smaller hospital would have garnered prior to the affiliation. To avoid this fate, smaller hospitals should first explore a range of termination options. In addition to documenting the potential benefits of the affiliation, each partner should detail ways they would be better positioned after the affiliation ends. An affiliation entered into without first demonstrating that it will fill a temporary need and leave each partner stronger is unlikely to serve the long-term needs of the organization.

Mitigating the Risks

Affiliations may entail significant risk, but participating organizations can mitigate potential downsides through a well-run affiliation process. The movement toward a partnership should include the following steps.

Establish a basis of comparison. The full range of partnership alternatives should be vetted to define the attributes that are unique to the

affiliation. Such comparisons also may identify any potential benefits from other arrangements that an affiliation will force the organization to forgo. A comparison of affiliation alternatives should give the organization an understanding of its market value as well as the economic and noneconomic consideration it could receive from a merger or outright sale. Because an independent hospital is often its community's largest and most important asset, its board should prioritize protection of its value and long-term viability during any decision-making process. The key starting point is assessing the hospital's business value, because that provides a baseline of comparison to evaluate the range of strategic alternatives.

Evaluate the exit. Analyses of the long-term implications of the affiliation should include whether the affiliation will facilitate the hospital's shift with the industry from fee-for-service reimbursement to population health management. Successful hospitals in coming years will take a central role in the patient care continuum and avoid marginalization as so-called cost centers. If hospital leaders intend to use the affiliation as an integration vehicle, then they should acknowledge the likelihood of a slow-motion-giveaway and the expected loss of economic and noneconomic value. If an affiliation will leave either party weaker than when the organization entered it, then it is not the best structure for the hospital.

Pair objectives with structure. Hospital leaders should remember that affiliations typically best fill specific, near-term needs. To meet organizational needs that are expected to persist or other long-term requirements, hospitals should explore alternative structures to affiliations. Alternatives to partnerships and affiliations that sometimes better fit a hospital's goals include building capabilities internally or pursuing joint ventures or full asset merger structures.

Careful Consideration Crucial

Affiliations can bring significant, short-term value. Many organizations have used these structures to fill gaps and improve services while maintaining ownership and local control. But organizations often do not recognize the risks these structures pose. An open and

rigorous assessment of both the full range of options and pitfalls of each is crucial as partnership activity accelerates. To mitigate risks of entering into an ill-advised affiliation that can hurt the organization over time, boards and management teams should first fully explore and understand the potential downsides.

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A Sustainable Growth Model: The Membership Substitution

By Rex Burgdorfer and Alex Voss

Hospital mergers and acquisitions have cycled in frequency over the past few decades but peeling the onion back we can identify certain interesting trends. One such trend, due to investor-owned hospital companies struggling and the need for scale, is the increased growth aspirations of non-profit hospital systems. By far, the most common form of hospital business combination among non-profit hospitals is the membership substitution. Given the increased use and the need to navigate competitive sale processes, it behooves the hospital industry to better understand this transaction structure.

While frequently cited as a "partnership" the membership substitution is often misunderstood. Using the term partnership is understandable, but it can also create confusion leading many to believe that the ownership and control of a hospital is not changing when, in fact, it is. Regardless of the source, the membership substitution remains understood only at a cursory level.

Given the increased recent use of the membership substitution, the acceleration in the need for scale and the disruptors and regulations making the hospital industry increasingly difficult to compete, this structure is likely to be used frequently in the coming years. In this article we endeavor to explain the membership substitution, its benefits and drawbacks as well as some of the practical implications for hospitals considering this structure.

Structure

In the corporate world, two options exist to acquire a company – buy the assets or by the stock equity. Equity sales are the more common type of sale in the public company domain and are analogous to

membership substitutions. Examples are endless but a two with some notoriety include P&G's acquisition of Gillette and Berkshire Hathaway's purchase of Heinz. Much like a membership substitution, in these arrangements the legal target entity remains in place with a new parent "stepping into the shoes" of the seller, as a sole new owner. Below are a number of the advantages of of this structure:

- Contractual arrangements are kept intact (i.e. 'as is') creating successorship for employees, collective bargaining, management and operations
- Operations continue as normal with business licensures, leases and working capital remaining unchanged
- Due diligence is simplified, regulatory scrutiny is frequently less burdensome
- Pensions, swaps and other liabilities remain in place streamlining the closing process and eliminating the need to satisfy external stakeholders (i.e. PBGC, derivatives market maker)
- No debt defeasance costs or pre-payment penalties are incurred
- Tail insurance needed

As seen in many of the above bullets, sellers frequently benefit from the simplicity of the stock transaction, the limitation of the costs and the extensive assumption of liabilities by the buyer. For these reasons buyers often prefer the acquire the assets in order to limit real and potential future legal obligations. Conversely, asset purchase transactions can have merit in industries, such as technology, in which specified assets can and should be isolated while other components or entities of a business are excluded from a business combination. This is why divestitures of subsidiaries are generally acquired via asset purchase.

Governance

As previously mentioned, typically the Buyer will "step into the shoes" of the Seller becoming the sole membership interest. As a result, the Buyer will achieve full ownership and control of the Seller. This relationship can be thought of like that of a parent company and

subsidiary, where the parent ultimately retains senior controls of the subsidiary. In connection with a member substitution transaction, the bylaws of each of the Buyer and Seller will be amended and restated in order to reflect the new governance structure and to provide for reserve powers that rest with the Buyer. Depending on the specifics of the transaction, the Seller may negotiate with the Buyer to have a limited minority number of board seats on the Buyer's board.

Economic consideration

In either a membership substitution or asset sale, there are generally three forms of economic consideration that the Buyer provides to the Seller of a hospital: (1) a purchase price, (2) assumption of liabilities, and (3) a commitment to spend capital in the future. The sum of these three components is "Aggregate Consideration" and must total "fair market value". The mixture of these forms varies based on the capital structure of the target and objectives of the parties. In a membership substitution, a purchase price is rarely paid, instead the Seller is relieved of its financial liabilities and secures a commitment to invest capital in the future. In many cases, non-profit Buyers are now the highest bidders in sale processes due to: (1) the inherent value to (a.) committing to investing in your future subsidiary is less burdensome than other forms of consideration and (b.) time value of money discounting future capital commitment and (2) the strategic importance of growth. So while for-profit conversations were popular a decade ago to extract a purchase price and create a community foundation with the proceeds, today the total economic consideration of a membership substitution transaction is often equal or greater. Evidence of the achievement of "fair market value" is critical to defend the transaction to any critics, notably the State Attorney General.

Financial features

- All assets are conveyed to the Buyer
- All liabilities should be assumed or guaranteed by the Buyer
- Capital expenditures are committed by the Buyer for routine and strategic needs in the future

- Rarely are charitable foundations created, if so it is most always restricted to supporting the hospital

Liabilities of the new subsidiary are frequently assumed or guaranteed by the new parent as a part of the obligated group, or can be retired via refinancing. Intercompany loans, support or guarantee arrangements as well as inclusion or exclusion in within the system's obligated group can create navigable issues. Balance sheet assets also face many similar circumstances. Is cash swept to corporate treasury? Who controls the foundation, how does it select grant donations, what types of projects can it fund? Will capital commitments come from future operations or funded from Buyer's cash?

As a result of the change in the organizational structure, it is important for each party to review its Master Trust Indenture, as well as any and all material documents ancillary to or apart from the Master Trust Indenture between a bondholder and any member of the obligated group. With the assistance of advisors (i.e. bankers and legal), the parties will want to determine whether each Master Trust Indenture can and should remain in place. Alternatively, the parties may determine that it is permissible and in the best interests of the combined organization to consolidate the debt under one Master Trust Indenture. If consolidation is permitted and desired, then the parties will want to determine under which Master Trust Indenture they wish to proceed post-closing. Typically, this decision is made to abide by relatively less restrictive bond covenants or to save on the cost of capital.

The parties should gain an understanding of how the consolidation may affect the rating of the debt of the combined entity, which will require a review of the rating agencies on analysis of pro-forma ratios. As a part of the bond analysis, the companies will want to identify any consents required of the bondholders, as well as a timeline and approach for obtaining such consents. In addition to potential for consents, there may be other covenants required by the Master Trust Indenture or ancillary documents, such as the delivery of legal

opinions, officer's certificates and posting of additional collateral of which the parties should be aware. Finally, the parties will want to understand the terms of any other debt or debt like securities (i.e. swaps) outside the Master Trust Indentures that may be outstanding to determine if the combination will be in violation of any covenants, and consider whether it is best to obtain consent or alternatively, redeem or pay off such debt.

Beyond the bond consents, the parties will also need to review all contracts to determine whether the change of control will trigger any consent requirements of third parties, any terminations or defaults under any agreements or rights of first refusals. These reviews can be particularly important in reviewing any joint ventures in which the parties are members or partners. Further, the parties will want to carefully review their contracts for non-competition restrictions, non-solicit restrictions and confidentiality provisions to fully understand the implications of the change of control.

Fallacies

Most of the confusion surrounding this structure in the non-profit world centers on whether or not the parties acknowledge that a sale is occurring. Often there are incentives to obfuscate reality, namely easing the PR messaging locally.

Part of the uniqueness of the membership substitution is the non-profit nature of the partners entering the transaction. While for profit enterprises can access equity, debt, and synthetic markets to raise capital to finance strategic growth, non-profit hospital companies are typically limited to the tax-exempt municipal bond market. Buyers of institutional debt are heavily reliant on credit rating (rather than growth and return prospects in the equity markets) in determination of the cost of capital or required yield. As a result, hospitals, and non-profits more generally tend to be more conservative with capital and have an affinity toward creative relationships to increase market share, revenue, and ultimately profits while not diluting one's rating.

Conversely, Sellers are becoming more sophisticated, however, and are questioning what they're getting in return for selling their hospital. We expect the give-away transactions of yesteryear are not likely to be repeated in the era of more commercially oriented partners.

Conclusion

The non-profit hospital industry is frequently commented on for its unique approach to M&A techniques and structures. We believe, this is unwarranted and incorrect. While corporate mergers are frequently thought of as tough and aggressive negotiations, the non-profit hospital industry is conveyed as completing 'partnerships' on friendly terms. As the stakes get higher, the Sellers become stronger, larger and more infrequent, and competition for attractive growth targets increases, this is changing. Transactions are now more in line with corporate norms - - following SEC conventions and regulations and Delaware Law. The cottage hospital M&A business is maturing and taking on characteristics of corporate transactions with negotiations surrounding technical topic such as representations and warranties, escrows, and breakup fees are becoming more common. Overall, this portends extensive use of the membership substitution as a structure for a significant share of the hospital M&A industry, and understanding the structure is in order.

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Hospital Joint Ventures Between Non-Profit and For-Profit Companies

By James Burgdorfer

Boards and managements of non-profit hospital companies are experiencing pressure to consider business combination transactions in light of the need for real consolidation of the industry. A whole-hospital joint venture is an alternative approach to ownership change that falls between the more conventional options available to non-profits (e.g., combining with a non-profit partner or an outright sale to a for-profit company). This article focuses on whole hospital joint ventures between for-profit and non-profit hospitals/health systems and seeks to provide an understanding of their basic structure, the reasons for entering into these arrangements, the types of non-profits that have entered into them, and the outcomes that have been experienced.

Whole-hospital Joint Ventures

By entering into a whole-hospital joint venture (WHJV), a non-profit organization is selling a majority position in its hospital system to a for-profit partner, and retaining both an equity stake and a role in the future governance of the "new company." Most often, these have involved ventures between non-profit and for-profit companies; there have also been a small number of WHJVs created by two non-profit companies. These have not, however, involved the payment of cash to the non-profit and do not represent a meaningful alternative to more traditional transactions. Also, the structure reviewed in this article should not to be confused with joint ventures involving specialized services (e.g., surgery centers). As a result, we will focus exclusively on WHJVs entered into by non-profits with for-profit partners.

Transaction Structure

As part of the negotiation of a change-of-control transaction, a WHJV is created by a non-profit hospital or hospital system (the "NP Hospital") and a for-profit hospital company (the "FP Partner") as they form a jointly owned for-profit company. The NP Hospital contributes one or all of its hospitals and the FP Partner contributes cash. This cash contribution, effectively, is used to purchase its majority ownership position in the WHJV and to fund its share of future capital needs. The NP Hospital contributes its "business" (i.e., the facilities, equipment, operations, and working capital) to the WHJV in exchange for cash and a minority ownership share in the WHJV. The amount of cash received by the NP Hospital is reduced by its share of the future capital requirements of the WHJV. As with an outright sale, the cash distribution received by the NP Hospital is typically used to retire its liabilities, and a foundation is created with the net proceeds. NP Hospitals that enter into these arrangements usually seek contractual protection against unforeseen change. In this regard, put and call options and rights-of-first-refusal have been commonly granted to the NP Hospital.

Governance

As with non-profit systems, WHJVs typically have two boards, one at the WHJV level and one at the hospital level. The WHJV board usually has parent-company authority regarding major strategic decisions and the hospital board's responsibilities consist primarily of day-to-day operating decisions. Until recently, WHJVs were structured so that board representation matched the equity position held by each party. However, more recent WHJVs have been structured so that the NP Hospital has 50–50 board representation, so long as it maintains an ownership position of at least 20 percent; this means that representatives of the former NP Hospital have the right to nominate 50 percent of the WHJV board. This is significantly more governance authority than would have been realized had they become part of a large non-profit system.

Operations

Once established, the WHJV is typically managed by an affiliate of the FP Partner under a management services agreement. These agreements last approximately five years, are renewable, and often compensate the manager on the basis of some percentage of the WHJV's net revenues. As majority-owner, the FP Partner typically consolidates the WHJV's results on its financial statements. Unlike a non-profit hospital system, WHJVs are able to make capital distributions; however, should there be additional capital needs, these distributions may be suspended. Future capital investment in the WHJV is derived from the initial capital contribution, loans from the FP Partner, and pro-rata contributions from the partners.

Non-Profit Participants

A wide variety of non-profits have chosen the WHJV structure, including community and religious sponsored, local government-owned, and academic hospitals. Most WHJVs resulted from the conveyance of the entire non-profit system. However, there have been several situations in which large non-profit systems (e.g., Ascension, Texas Health Resources) elected to build a new hospital via a WHJV with a for-profit partner. Since their first development in the early 1990s, approximately 30 WHJVs have been completed; they represent a small but meaningful minority of all change-of-control transactions. These WHJVs now contain 59 former non-profit hospitals, or approximately two hospitals per transaction. They have most often been entered into by non-profits with rich traditions, significant market reputations, and heavily committed boards of directors. The average size of the non-profits that entered into WHJVs was approximately 50 percent larger than the average size of all non-profits participating in business combination transactions with for-profit acquirors over the same time period. Consistent with the hybrid nature of WHJVs, non-profit hospitals have had several motivations for selecting this approach. These include benefits generally associated with conversions (sale to a for-profit) and benefits unique to this structure. Conversions

hold several common benefits, including creation of a foundation, improved access to capital, and transfer of management to an experienced and broad-based group. The benefits associated with the WHJV structure itself relate primarily to the local accountability that results from the governance construct, and the investment opportunity inherent in maintaining an ownership stake in the hospital system. In our view, governance authority has been the most important objective sought by non-profits in choosing the WHJV structure. In comparison to an outright sale, the WHJV structure involves a significant trade-off between foregone cash proceeds (i.e., from the minority stake which is not sold) versus the significant governance authority that results. In order for the WHJV structure to be compelling, the non-profit must have a board that places enormous value on local accountability and a debt level that allows this option to be financially feasible.

For-Profit Participants

Six different for-profit companies act as the FP Partner in the 30 WHJVs. One particular management group, and their career progression, accounts for the presence of three of these companies. In considering partners for prospective WHJVs, the major for-profit companies fall into three groups: most are somewhat ambivalent and willing to consider, but do not seek, such structures; several are not willing to enter into them; and one is very focused on creating WHJVs.

Outcomes

In practice, WHJVs have been very successful and nearly all those that have been created remain in place today. Only one non-profit has exercised its put option, and this was due to a church-related refocus of mission, not displeasure with the WHJV. One FP Partner was recently bought out by the NP Hospital; this resulted from the sale of the original for-profit sponsor to another for-profit company.

Future Application

WHJVs have represented an attractive alternative to outright sale or merger and have performed well in practice. Juniper considers these to be highly evolved and proven structures. As non-profit boards consider business combination transactions, WHJVs are often a viable alternative, particularly in circumstances in which boards place great importance on local governance. In our view, non-profits are going to commonly consider business combination transactions on a proactive basis in the near future. This is in contrast to defensive motivations, which dominated transactions during the past decade. As a result, WHJVs will often represent an attractive alternative that warrants serious consideration.

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The Hospital Joint Venture

By Ken Marlow and Barry Sagraves

Since the enactment of the Affordable Care Act (ACA) in 2010, more and more hospitals and health systems have entered into some sort of affiliation, whether through acquisition, membership substitution, joint venture, or clinical affiliation. This trend is a result of the mounting pressures hospitals and health systems face in the current healthcare environment. Yet, fundamental change in the makeup of the hospital market also paves way for innovation, which includes new ways that organizations may partner to confront these challenges. The joint venture structure is one such innovation.

For those hospitals and health systems that are financially sound and have sufficient capital, entering into an affiliation allows them to best position themselves for future success—to thrive rather than just survive. Evaluating strategic alternatives from a position of strength allows the board of a hospital or health system to take its future into its own hands and identify affiliation partners that complement and enhance its operations, capitalization, compliance, and quality functions. Exploring a range of joint venture alternatives has been found by many systems to be a "best of both worlds" approach—combining the installed market presence and reputation of a non-profit system with the scale, access to capital, and management expertise of an investor-owned company.

Most hospital and health system boards are aware of the trend of consolidation; however, many fail to appreciate the full range of strategic alternatives that may exist (including the joint venture structure) and the processes and tactics that can identify and realize the board's desired outcomes. This publication examines 1) the potential advantages of joint ventures; 2) expected trends and future developments with joint ventures; and 3) how to go about the process of exploring a joint venture, including selecting a joint venture partner.

Table 1: Challenges and Emerging Opportunities

Challenges Posed by Industry Changes	Emerging Opportunities
• Reimbursement cuts year over year • Increasing costs and expenses for information technology in connection with electronic health records, meaningful use, and collection of data for quality metrics comparison, all key elements of successfully managing population health • The requirement for effective compliance programs and, in the event of noncompliance, being subjected to repayments, penalties, and other sanctions • Increasing challenges in financing capital expenditures, and continuing or increasing pension funding challenges	• Vertical integration, where health systems may vie to "control the premium dollar" rather than being a price taker from insurance companies • New ways of developing and sharing clinical protocols to reduce variation in outcomes and improve quality • Make capital investment decisions on a regional basis, across all elements of the health system

Advantages of Joint Ventures

Hospitals and health systems are looking to joint ventures for a number of reasons, many that are common but others that may be unique to potential partners. Some of the most common factors are:

- **Governance**: One of the key areas that many boards find attractive about joint ventures is that the current organization remains an owner and is directly involved in the governance of the venture. While gaining access to increased capital and opportunities, the local board remains very much "at the table" in managing the organization. There is, however, no standard model among potential partners, and both the legal structure and the day-to-day realities of decision making must be carefully explored and negotiated.
- **Investment potential**: A second potential advantage in a typical non-profit/investor-owned joint venture is that the non-profit corporation retains an equity stake in the business, which it will expect to increase in value over time. In addition, as a charitable organization, it will be able to diversify its holdings with the sale of an interest in its current business, reducing its overall portfolio risk.
- **Access to capital**: The capital needs of a hospital or health system are extraordinary. A hospital that enters into a joint venture has the benefit of additional sources of capital. A financially healthy partner can share the burden of capital investments, whether for working capital, routine, or strategic capital projects. Even with a fairly healthy financial position, many organizations find

themselves facing limits to their debt capacity or significantly underfunded pension plans. These liabilities can often be eliminated as part of the joint venture transaction.

Enhancement of quality: In the evolving healthcare environment, the hospitals that provide the best quality of care will be rewarded, while those that do not meet the requisite standards will face consequences. Specifically, the ACA includes a value-based purchasing program, which rewards hospitals that exceed quality measures and penalizes underperformers with payment cuts. Partners that have a history and reputation of clinical and quality excellence, as well as access to highly specialized medical services, will provide the assistance to ensure not only that patients are receiving the best quality of care, but also that, as a result, the hospital is rewarded financially for providing excellent care.

- **Physician recruitment, retention, and alignment**: Another way a joint venture can strengthen a hospital or health system is through physician recruitment and retention. Partners that have strong physician networks and a proven ability to attract and retain physicians will continue to be critically important to the success of a hospital. Partners that can provide resources to aid physicians and caregivers in skills development and career plan development of staff at all levels of the organization will be attractive to hospitals. In addition, investments in a significant infrastructure of recruiting, the sourcing of specialists and practice management experts, and support for promoting practices and retaining quality physicians will be instrumental in ensuring success. A final, psychological point cannot be underestimated: physicians, particularly in an employment situation, want to "join a winner" that can offer them the potential for a secure professional and financial future.
- **Efficiencies and bargaining leverage**: With the implementation of the ACA, the cost of doing business has increased, while reimbursement has decreased. This has placed increased pressure on hospitals and health systems to find efficiencies and engage in cost-cutting efforts. Through joint ventures, healthcare organizations can find synergies in various aspects of the operations, such as back office, management, and administrative functions. They also may have more leverage in negotiations with suppliers and

payors. In addition, the larger scale may provide for better terms with respect to health and welfare benefits, as well as insurance policies.

- **Continuation and expansion of services**: The continuation and expansion of healthcare services is critical to the success of hospitals and health systems. A joint venture with a strong partner can solidify the ability of the organization to provide existing services and in many cases provide additional specialty services that are not currently offered at the hospital. With the addition of a joint venture partner, the hospital also may be better positioned to offer additional ancillary services, such as diagnostic, laboratory, and pharmacy services. By ensuring the continuation and expansion of services, the patient is more likely to seek care within the local community.

Hospitals and health systems across the nation are faced with challenges unlike ever before. We have provided here a brief overview of the advantages that many hospitals are finding in joint ventures and other affiliations. In the following section, we speculate as to the future direction of hospital joint ventures and solutions it may provide to the healthcare industry.

A Glossary of Hospital and Health System Transaction Structures

Below are the key structures seen in recent partnerships announced by hospitals and health systems:

Seller joint venture: Seller joint ventures (SJVs) are typically, but not always, formed between a community hospital and an investor-owned company. The investor-owned company acquires a majority interest in the hospital (usually 60–80 percent). However, local control is preserved for the community via 50 percent hospital representation on the joint venture board. In these arrangements, the hospital gains access to needed capital while maintaining a collaborative culture, and the investor reaps returns if and when the hospital partner

grows its market share. *Example: LHP Hospital Group's joint venture with Portneuf Medical Center in Idaho.*

Buyer joint venture: Buyer joint ventures (BJVs) combine the respective expertise of a clinical partner or a system with a regional presence with an investor-owned system. The clinical partner holds a minority of the equity interest (typically 3–20 percent) and is responsible for overseeing medical safety and quality or providing regional services. The investor-owned partner provides capital (typically 80–97 percent), management capabilities, and economies of scale to run the community hospital. These partnerships have been very successful and appealing in recent years. Together, the BJV goes out to acquire hospitals and health systems. *Example: Duke LifePoint's joint venture that acquired Conemaugh Health System in Pennsylvania.*

Shelf joint venture: In order to be ready to compete effectively for acquisition opportunities, it may be advisable to structure the BJV before there is an actual target available. Typically a letter of intent is signed between the prospective joint venture partners, which is then made binding simultaneously with the closing of the acquisition. A shelf joint venture is a strategy for forming a partnership in advance of a partnership opportunity.

Consolidation transaction: A consolidation occurs when two parties combine to create a new parent company with a self-perpetuating board. Consolidation transactions are difficult to execute but typically double the size of the individual partners, quickly achieving scale. This was a very popular structure in the 1990s and has seen a revival post-health reform. *Examples: Advocate Aurora Health Care (and previously Advocate Health Care) in Chicago, Banner Health in Phoenix and Sentara Healthcare in Virginia.*

Membership substitution: A membership substitution is the most common structure between merging non-profit hospital systems. The seller transfers its membership to the non-profit acquiror, which becomes the new "owner." The structure is used in non-profit transactions where the seller wants its corporate structure to remain intact

post-closing, or the buyer wants to assume, rather than retire, the liabilities. *Example: Meriter Health System joining UnityPoint Health.*

Asset sale: The typical structure for an investor-owned acquisition of a non-profit. The buyer acquires the assets (working capital, fixed assets, intangibles) and excludes most liabilities, which the seller then retires. Remaining funds are used to establish a local community foundation that can be used for various charitable purposes, including promotion of healthcare in the community. *Examples: Sale of Marquette General Health System to Duke LifePoint and sale of Guthrie Medical Center to Mercy Health.*

New Frontiers in Hospital Joint Ventures

In this section, we speculate as to the directions this flexible yet complex organization structure may take in the future and solutions it may provide to the healthcare industry. We also cite some recent examples of joint ventures and other affiliations and assess the circumstances under which success is more likely than not.

Seller and Buyer Joint Ventures

There are many examples of hospital joint ventures. These are often referred to as "seller JVs," where a hospital that otherwise would have been sold retains a minority stake in a new company. These JVs usually involve a non-profit as the minority partner and an investor-owned company as the majority and managing partner. The benefit to the "seller" is that it remains involved in the governance of the JV and has an ongoing financial stake and potential return, as well as receiving a cash payment for value of the assets contributed to the JV.

A more recent phenomenon is the "buyer joint venture," in which two parties team up to acquire a hospital. The most prominent of these has been Duke LifePoint (DLP), the joint venture between Duke Quality Network, a North Carolina non-profit corporation, and LifePoint Hospitals, a publicly traded hospital company. DLP has acquired through acquisitions or joint ventures numerous hospitals since its inception in 2010.

These arrangements are becoming more mainstream, as is demonstrated by Watertown Regional Medical Center's decision to create a seller JV as the first for-profit conversion in the state of Wisconsin.

The Next Big Thing

More recently, a number of creative JVs have been announced that are structured to enable hospitals and health systems to manage populations, collaborate more effectively with managed care providers, and better respond to the compliance demands and reward structures placed upon health systems by the ACA. These structures, five of which are described below, could be precursors to fully integrated health systems, which many believe will be the dominant financing and delivery model of the future.

We have witnessed an increase in the number of multi-party JVs, which adds significantly (some might say exponentially) to the complexity of both negotiating and operating the resulting organization.

The transactions listed below range in their complexity from true joint ventures to more of the "vertical" joint ventures that involve payors and large employers:

- **Tenet, Ascension, and Dignity Health**: The three-way JV between Tenet, Ascension, and Dignity Health (now part of CommonSpirit) in the Tucson, Arizona, area is an example of parties with different strengths, expertise, and resources joining forces to become a more efficient and effective provider. Dignity Health will invest $30 million in cash and hold a minority interest in a proposed joint venture with Tenet Healthcare Corporation and Ascension Health. Tenet will hold a 60 percent ownership interest in the venture, which will operate Carondelet Health Network, a subsidiary of Ascension Health. Dignity Health and Ascension will each hold a 20 percent ownership interest. Carondelet Health Network includes three hospitals, two medical groups, and other assets. While creating a JV with three partners is usually significantly more complex than it is with two partners, the logic in this

example is that all partners get to spread their risk while also having the opportunity to pursue additional new business opportunities. Such arrangements usually work best when the parties are reasonably comparable in size, sophistication, and financial strength, and when all benefit to a similar degree from the JV.

- **Stratus Healthcare**: Possibly the largest recent multi-party arrangement is Stratus Healthcare, a 16-system (which owns and operates 30 hospitals) JV in Georgia that formed in order to pool resources, coordinate information, and manage population health in the region. The new organization is a not-for-profit limited liability company and was conceived as a way for providers to collaborate while remaining independent. As with most such organizations, two of the Stratus members took the lead in its formation in 2012, and then brought the others along a year later. The leap to a change of ownership or full integration is too large for many organizations to make in one step, particularly those that are doing reasonably well financially. "Testing the waters" in this way while gaining some benefits of scale works for both the smaller hospitals and the larger ones leading the charge—that tend to prefer to get to an ownership stake sooner rather than later.
- **Vivity:** Anthem Blue Cross and seven health systems in Los Angeles and Orange County have created a joint venture to offer a narrow-network product in that region—Anthem Blue Cross Vivity (Vivity). The partners plan to share data and seek economies of scale to offer higher-quality, lower-cost products than their competitors. Profits and losses are to be shared equally among the partners. Vivity will initially target large employers in the Los Angeles market, and the "narrow network" Vivity plan is designed to align the financial risks and rewards of providers and payors through population health management in a manner that will (hopefully) be an appealing alternative to the high-deductible plans many large employers offer their employees. On its face, Vivity appears to be well positioned to facilitate Anthem's and its hospital affiliates' ability to provide an alternative to payors such as Kaiser and providers of healthcare services in the Los Angeles area. There are still many questions to consider as we evaluate partnerships like Vivity. For instance, will the hospital systems be both willing and able to share information and expertise with one

another while implementing the population health management tools? How will the Federal Trade Commission and state agencies react to hospital systems potentially sharing competitive information outside the admittedly murky framework of clinically integrated organizations?

- **Puget Sound High-Value Network**: This network of eight hospitals (including those of CHI Franciscan Health and Virginia Mason), more than 160 clinics, and almost 3,000 specialty and primary care providers will contract directly with employers in an effort to offer higher-quality, lower-cost benefits to the self-insured market. Marketed specifically to self-insured employers with 50 employees or more, the network offers competitive rates by selecting network providers that are committed to services at reduced unit costs, while still maintaining a focus on quality through the development of ongoing clinical initiatives. Similar to Vivity in its goal of providing a narrow(ish) network model to the market, this is quite distinct in that the network is a direct-contracting model without a health plan. As such, it may be a more applicable model for providers in other markets that do not have a health plan market but do have the data and care-management skills to successfully take on capitation-like risk.

We expect to see an increasing number of these "vertical" joint ventures in coming years as trying to balance quality, access, and cost control becomes ever more central to hospitals' success. The "glue" provided by a corporate structure like the joint venture will be important as employers and government programs seek stable partners to minimize their healthcare costs over time.

When to Consider a Joint Venture

Whether a joint venture is the appropriate corporate structure for a given activity is a matter of the facts and circumstances in each particular situation (see **Table 2**). Form should follow function.

Table 2: A Joint Venture May Be the Most Appropriate Structure If…

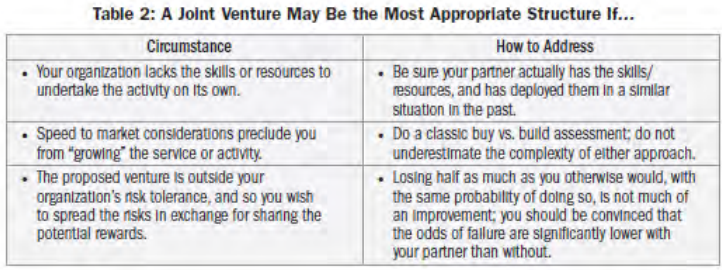

Table 2: A Joint Venture May Be the Most Appropriate Structure If...

Circumstance	How to Address
• Your organization lacks the skills or resources to undertake the activity on its own.	• Be sure your partner actually has the skills/ resources, and has deployed them in a similar situation in the past.
• Speed to market considerations preclude you from "growing" the service or activity.	• Do a classic buy vs. build assessment; do not underestimate the complexity of either approach.
• The proposed venture is outside your organization's risk tolerance, and so you wish to spread the risks in exchange for sharing the potential rewards.	• Losing half as much as you otherwise would, with the same probability of doing so, is not much of an improvement; you should be convinced that the odds of failure are significantly lower with your partner than without.

JVs have progressed significantly over the past several years, to where they are a viable option to help organizations provide services or enter markets they would otherwise be unable to access. They have progressed from a way to align with physicians, to a means for building hospital systems, and now to a potentially revolutionary approach to population health.

Building a Hospital Joint Venture: A Blueprint for Success

Here we explore the "nuts and bolts" of considering and creating a hospital JV, which will allow us to bring the hypothetical and theoretical into the practical. If you are a hospital or health system considering forming a JV, there are some important factors to think through before embarking on this complex process.

Hold It Right There—Before You Even Get Started…

JV partnerships have the ability to address many challenges faced by hospitals and health systems today. However, it is easy to "default" to a joint venture structure without thinking deeply about whether that is in fact the best way to organize collaborative activities. On the surface, a JV may appear to represent the "best of both worlds"—it can bring together the strengths of two or more organizations to create a new "super organization" (for example, the capital and community hospital operating expertise of an investor-owned company with the clinical prowess and brand appeal of a non-profit system or academic medical center). It is, however, important to not lose sight of

what is driving the exploration of a potential JV formation. What are you trying to achieve as an organization? What problems are you trying to solve, and what outcomes are you seeking for your community? Do these goals align with those of your potential partners? While it's possible (and maybe even common) for partners to seek different objectives, it's also important for the structure of the JV to flow from these objectives. Form should always follow function.

All too often, potential JV partners will get deep into collaborative talks only to discover that the organizations have fundamentally different goals for pursuing a partnership. One may want to become a preeminent hub for medical research, while the partner may be more focused on creating a regional system in order to create economies of scale. One organization may want to better fulfill its charitable mission by creating a large locally governed foundation, while another partner may want to leverage the branding of the partner in order to fuel new acquisitions outside of the market. It is important to be up front with all potential partners and to clearly outline:

1. What the JV will allow you to achieve that could not be achieved alone
2. What you are willing to commit as an organization in order to fulfill these goals
3. What you are expecting your potential partner to commit

Only then can a JV structure begin to emerge that can help all parties meet these goals within existing constraints. And, who knows, perhaps the delineation of goals, expectations, and commitments will make it apparent that another new, unanticipated party should also be involved, or that a different form of relationship may be preferable. The front-end exploration of goals and form are vital to laying the groundwork for a successful partnership that will thrive far into the future.

A JV Doesn't Always Mean 50-50

A common misconception is that a JV involves two parties in a traditional 50-50 split. From the outside, this seems like the path to least resistance and the structure that will guarantee fairness and equality for both participants. However, sometimes goals will dictate unequal

ownership and governance splits. It's important to consider how the ownership split should be arranged. For starters, consider these questions:

- Is one party committing more capital, expertise, time, or effort?
- Is one party exposed to more risk than the other(s)?
- Is the JV more important to one party's overall business success than it is to the other(s)?

It's important that the structure of the JV follow the level of commitment from each participant. A less-committed party (financially or strategically) can lead to the weakening of a JV—or worse, can do real damage to the other involved parties. Everyone needs a proportionate amount of "skin in the game".

Cultural Alignment: All That It's Cracked Up to Be?

One of the biggest buzzwords in hospital and health system business combinations is "cultural alignment." While it is crucial that the two organizations are culturally *compatible*, this is not the same as having cultures that are *identical*. For example, it is possible for each organization to highly value quality and employee fairness, but approach them in different ways.

A health system JV can be conceived of like an all-star team in sports. These "super teams" are made up of the best-of-the-best players from what are, usually, rival teams. While the players need to cooperate effectively on the team, they do not need to be the best of friends off the court. It is important that they have a common purpose and agree on the plan for achieving success, and be committed to the shared goal.

The Nuts and Bolts of a JV

Once a hospital/health system decides this is the path it wants to pursue, the following is an outline of how to start the process of forming a joint venture. This is written with the assumption that the organization has not yet identified a partner. If a partner has already been selected, many of these steps may not be necessary.

1. Prepare the Board and Management Team for the Process

Select an investment banker and counsel. Management and boards typically work with an investment banker to assess the needs of the market, outline strategic objectives, lead the request for proposals, set timelines, assist the parties with their negotiations, and more. A transaction advisor with experience working in this area will allow the board to take a step back, think more broadly, and may also assist in maximizing the competitive process to ensure the best partner is identified. In addition, counsel can be helpful in advising the hospital on the negotiation of the definitive agreement, assessing the potential risks and benefits of a joint venture, and assisting with regulatory approvals and other review processes.

Define objectives and review options. The process, and ultimately the partner selected, will be guided by answering some fundamental questions early. At this point, it's important to also compare a range of strategic alternatives, practical implications, and successful models. The board, management team, and investment banker should discuss the preparedness for the new healthcare environment and the expectations for overall size and positioning.

2. Arrange the Joint Venture

Sign a confidentiality agreement. By signing a confidentiality agreement, all parties involved ensure that all information exchanged will be kept quiet.

Execute an information memorandum. In the event the hospital decides to pursue the process and needs to identify the best joint venture partner, it will need to prepare an information memorandum. This document will set forth key information regarding the hospital and some basic guidelines as to the needs of the hospital and the potential strategic alternatives it is considering.

Issue a request for proposals. In order to solicit information from potential partners, the hospital (via the investment banker) will issue a request for proposals. This is an opportunity to find out the level of capital investment the prospective partner is willing to commit, its commitment to quality of care, and its historical financial

performance or patient satisfaction information. In addition, assuming the hospital has identified its goals, the organization can ask specific questions to gauge the potential partner's ability to meet or enhance its goals.

Negotiate the term sheets and sign LOI. Once the hospital has identified its joint venture partner, the parties will want to work on a letter of intent or term sheet. The purpose of the document is to provide the prospective partner a chance to focus on the goals of the joint venture and make sure the partners are on the same page. Some of the following themes should be considered:

- **Leadership and governance**: The parties will need to determine what each organization will contribute to the joint venture and the ownership percentages of each. They will also want to determine which entity will control the day-to-day operations of the joint venture. Will there be equal representation on the board or will one party have majority control? Put impactful people on the board and into the management of the JV.
- **Charitable purpose**: In the event the hospital is a tax-exempt 501(c)(3) organization, it will want to ensure that its charitable purposes are being fulfilled through the joint venture's operation of the hospital. The hospital will want to confirm that the joint venture will conduct a community health needs assessment, adopt an implementation plan, and take other actions in order to comply with 501(r) requirements.
- **Financials**: An investor-owned hospital company likely will require that the financial statement of the joint venture be consolidated with the financial statements of the hospital. As a result, there may be tension between the goals of an investor-owned entity and those of a tax-exempt hospital.
- **Performance expectations**: The parties will want to identify key decisions that require approval of the parties or the governing body. If there were ever a deadlock, how would the partners resolve the dispute? For example, if the partners have made a good faith effort but cannot reach an agreement on capital or operating budgets or an additional capital contribution that may be required, do they want to have the ability for one partner to buy out the other?

3. Tell Your Story
Leadership must agree upon and communicate a well-planned, consistent, and truthful series of messages to all affected parties (employees, physicians, patients, elected officials, and payors) that accurately describes the hospital's operating environment and conditions, the available alternatives being considered, and, ultimately, the actions to be taken to accomplish the organization's goals. This step is crucial to execute prior to going to regulators, as you will want people behind you in this decision, not against you. Opposition can be your worst enemy as you head to regulatory bodies for approvals—particularly if you are considering a conversion from non-profit to for-profit in a state that has never done so.

4. Negotiate and Execute a Definitive Agreement
The partners will want to memorialize their understanding by entering into a definitive agreement, which will involve the following:

- **Contribution agreement**: This agreement provides for the contribution of capital to the joint venture. It also sets forth the ongoing capital commitments, continuation of services and requirements to maintain certain levels of indigent care, and includes the conditions required to consummate the transaction (e.g., regulatory approvals and no material adverse effect), as well as allocation of liabilities and obligations of the parties.
- **Joint venture governing document**: This agreement sets forth the rights and responsibilities of the partners. This agreement also sets forth the governance structure of the joint venture, key decisions that require approval of the members, and unwind events should the partners find themselves in a deadlock.
- **Management agreement**: In the event that the joint venture appoints a manager to run the day-to-day operations of the hospital, it will enter into a management agreement with the manager, defining their responsibilities and those of the governing body of the joint venture.

5. Gain Necessary Third-Party Approvals
The change of ownership of the hospital to the joint venture could be subject to state and/or federal approval processes, including state

attorneys general for joint ventures involving a conversion from non-profit to for-profit, the Federal Trade Commission for transactions exceeding the Hart-Scott-Rodino thresholds, and Certificates of Need by the applicable Department of Health.

6. Close the Transaction

Once the previous steps are complete, the organizations will work towards a closing, which will finalize their new partnership. At this point, this is when the real work begins.

The successful execution of a JV begins in the planning stages. A JV's form must always tie back to its function. Only then can the mechanics outlined above properly solve for the challenges of tomorrow's healthcare landscape. Remember that while a JV can appear to be an easy solution on the exterior because it represents the "best of all worlds," its ultimate success will reside on clear vision and commitment from all participants.

Conclusion

In recent years, a growing number of hospitals and health systems have entered into joint ventures or other forms of creative partnerships in an effort to respond to mounting financial and competitive pressures as well as to drive innovation, efficiency, and growth in the industry.

Most hospital and health system boards are aware of the trend of consolidation; however, many fail to appreciate the full range of strategic alternatives that may exist and the processes and tactics that can be used to best position the health system for success. There are many potential advantages to joint ventures and many recent examples of successful arrangements, but the boards and executive management teams considering a potential joint venture structure should first become educated on the process prior to embarking upon this complex and creative endeavor. We hope this handbook can serve as a launch pad for this educational process, with the intent of helping board members to further the long-term success of their health systems.

This article was originally published by The Governance Institute and reprinted with permission.

Editors' Note: This article predicted many of the trends that came to pass in the years following its publication, including such notable consolidation transactions as the merger of Advocate and Aurora in the Midwest.

Consolidation Transactions: Will They Make a Comeback?

By James Burgdorfer, Jordan Shields and Rex Burgdorfer

A consolidation transaction is a business combination in which two or more unrelated entities agree to form a new parent company. Subsequent to the transaction, the new parent owns the assets and assumes the liabilities of the former individual companies. Unlike most other legal forms, neither party succeeds the other. Instead, the parties agree to become part of a jointly held new company.

These are typically cashless exchanges between non-profits in the same market—often competitors in urban areas. They are sometimes called "new holding company" transactions; we will refer to them here as "consolidation" transactions. These can be easily confused with "mergers" by casual observers. However, a merger is a transaction in which one party overtakes the other—both ownership and control change, and the overtaking party either becomes the parent of the other, via a member substitution, or the other party ceases to exist, via an asset purchase.

Industry Consolidation

The potential reappearance of consolidation transactions should be considered in the context of the need for industry consolidation and the formation of larger companies. Many factors point toward the need for the industry to consolidate into a more rational structure. Healthcare costs have reached the point of crippling the U.S. economy. Even prominent periodicals, including The Economist and The New Yorker, that have historically paid little attention to the economic impact of the fragmented hospital industry have recently described the role that small hospital companies play in the healthcare

crisis. Ultimately, controlling the increase in healthcare expenditures is the key to getting the nation's fiscal house in order.

A significant body of research supports the view that large, multi-hospital companies are more efficient than small hospital companies. Large systems understand that healthcare reform creates the need for greater scale in order to lower the cost of capital, improve access to physicians, strengthen management breadth and expertise, and allow sharing of medical best practices. Despite this, and broad acceptance of the notion that scale improves clinical and financial performance, many small and mid-sized hospital companies continue to resist change. We believe that this is largely due to the long-held, and still pervasive, focus on local issues and control.

Participants, Features, and Limitations

As discussed, consolidation transactions are cashless combinations in which a new entity assumes the assets and liabilities of the individual companies that existed prior to the combination. They differ from most other business combinations in that neither participant overtakes the other. Other arrangements result in one party surviving and the other being subsumed or eviscerated.

In addition to these unique structural features, consolidation transactions are usually accompanied by certain common social features. They were actively used during the 1990s as a response to the onset of managed care—a powerful external factor. The shared concern felt by many boards regarding this challenge contributed significantly to the large number of these transactions. Also, the boards of participants in these transactions tended to be more geographically diverse than those of most 501(c)(3)s and, often, their board's motivations and objectives extended beyond local issues. At a certain level, these boards also shared a preference for outcomes devoid of winners and losers.

The initial composition of the newly consolidated entity's board is often determined by the relative economics of the two parties. Occasionally, however, equal representation, without regard to

differences in value, is granted to both sides. Subsequently, boards are either self-perpetuating or each constituency continues to nominate its proportionate share of the board. The former is obviously most beneficial to future governance because it obviates the fractionalization that can occur with other formats. This approach, however, certainly requires the broadest and most enlightened perspective by both boards and, probably, a healthy dose of ecumenicalism.

Most of the companies created by these transactions have been successful in their markets and many are regional leaders. At inception, most were combinations involving two mid-sized hospital systems in the same metropolitan area. Exceptions to this include at least one transaction in which two geographically disparate systems combined. Most of the resultant multi-hospital systems experienced a very similar pattern of corporate development subsequent to formation. Similar to most 501(c)(3)s, they were not acquisitive until healthcare reform seemed likely. Typically, these companies made very few acquisitions during the first decade or so following the combination. Now, however, many of them are considering the merits of growth and are likely to become acquisitive.

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V. Achieving Success

Defending the Deal: AG Review Process

By Lanta Wang, Ken Marlow and Rex Burgdorfer

As the delivery of health care continues to evolve and hospitals bear additional pressures to adapt to new payment models, more non-profit hospitals are partnering with for-profit providers, through a sale, joint venture, or other arrangements.

Partnerships between independent non-profit hospitals and larger health care systems (non-profit and for-profit) have been growing over the past two decades. As more non-profits look to the future, many have determined that to continue to offer services to their communities and remain viable under health care reform, they must consider strategies that involve partnering with a larger, well-capitalized system. This is particularly true given the unique handicap imposed on non-profit organizations; namely, having access to only one source of external capital—debt. This is also in direct contrast with other large industries in which equity and other capital markets can be readily tapped. As a result, many non-profit hospitals are considering conversions into for-profit entities to gain access to capital.

When undertaking a conversion from a non-profit to a for-profit entity, most states require non-profit hospitals to go through an attorney general (AG) review process, and some states require approval by a court and other regulators before the transactions can close. This can be a particularly unfamiliar and time-consuming part of the transaction, yet it is imperative to consummating the sale or partnership. Adequate preparation and sound process will better equip the parties for success and avoid potential roadblocks to completing the transaction.

The Role of the Attorney General and Other Regulators in the Conversion Process

Attorneys general are oftentimes the only officials with authority to conduct comprehensive, advance review of hospital conversions. Other governmental agencies may oversee some aspects of conversions, but their authority generally is limited. For instance, a conversion transaction that distributes cash is considered a tax realization event that implicates the oversight of the Internal Revenue Service (IRS). Additionally, hospitals built with Hill-Burton Act funds must provide significant amounts of uncompensated care; thus, a conversion would trigger the oversight by the U.S. Department of Health and Human Services. Furthermore, the Federal Trade Commission (FTC), the Department of Justice (DOJ), and state antitrust units also may analyze conversions to determine whether they jeopardize competition. In contrast, the AG likely will examine all of these factors in his/her review process.

The responsibility of the AG (and in some states, the courts and/or the state regulators) is rooted in state statutes (most commonly under state corporation law) and/or the common law charitable trust and *cy pres* doctrines. As directed by state statutes or as *parens patriae* under common law, the AG must protect the interest of all public beneficiaries of charitable assets—in this case, the assets of the non-profit hospital. In this protective role, the AG is looking for any indication or evidence of self-dealing, improper use or diversion of charitable funds, or inadequate value for assets being transferred. To solicit the necessary information to evaluate whether such issues exist, the AG typically requires that non-profit hospitals and/or the buyer or partner submit an application to approve the transfer of the assets. The preparation of the application is a significant undertaking that entails the gathering of information on many elements of the transaction, such as the process for selecting a buyer or partner, the determination of the hospital assets' value, and the commitment by the buyer or partner with respect to capital investments and charity care spending in the future. The burden of proof to produce a comprehensive packet of information rests most heavily on the seller hospitals. Very commonly, the hospitals and their advisors will prepare a transaction

narrative and other documentation to demonstrate the thoroughness and rigor of the decision-making and transaction process.

Questions to Be Prepared to Answer

The parties to the transaction, and more specifically, the governing board of a non-profit hospital exploring any strategic alternatives involving a joint venture or a sale with a non-profit or for-profit company, should be able to provide evidence to address the following questions:

- Why is the non-profit hospital evaluating a change-of- ownership option?
- How did the non-profit governing board select a particular buyer, partner, and partnership structure?
- How did the non-profit governing board establish the "fair market value" for the assets of the hospital?
- Were the non-profit governing board's actions free of self-dealing and inappropriate personal gain?
- Does the transaction benefit the public's interest?
- If the transaction generates cash proceeds, will such proceeds be used for charitable purposes?

Common Features of Conversion Review Process

While state law and AG-imposed guidelines that specifically address non-profit hospital conversions vary widely across states, many common features of the review process are worth noting. Here we detail the crucial steps and considerations of the process from a practical standpoint:

1. Communication with the AG

Making a positive first impression with the AG and the AG's staff is critical in the review process. It is important that the parties proactively reach out to the AG early in the transaction to make the AG aware of the potential sale or joint venture. This communication should occur prior to any public announcements of the transaction to

ensure that the AG is not surprised by the news. Communicating early also serves to open up a dialogue with the AG with respect to the AG's expectations and requirements of the review process.

2. Notice/Letter/Application

The primary requirement of the AG review process is a formal notice, letter, or application to the AG. Most states stipulate that the hospital and/or the buyer or partner must notify or submit an application to the AG a certain number of days prior to the contemplated consummation of the transaction and may allow the AG additional time for review as needed; some states do not have a specified time period. An open line of communication with the AG with respect to the timeline is vital, as any delays in receiving the approval of the AG will delay the closing of the transaction. The content of the formal notice, letter or application to the AG may be set forth in statutes or guidelines provided by the AG. In states where neither exists, the parties will need to work closely with the AG's office to determine its expectations. Typically, the application will include all or a combination of the below categories of information; keep in mind, however, that the AG is free to request any additional information that he/she views as necessary to evaluate the proposed conversion:

a. General information: In the notice, letter or application, the parties will set forth an overview of the hospital and the hospital assets, the reasoning for seeking a buyer or strategic partner, a description of the bidding process, information regarding the buyer/partner and its current and historical operations, a highlight of the critical terms of the proposed transaction, and information relative to the expected impact of the proposed transaction on the community.

b. Organizational documents: The application typically requires governance documents of the parties involved. The application also requires the proposed corporate structure of the hospital post-transaction.

c. Transaction and related documents: As a baseline, the AG will require a final or near-final definitive agreement for the sale or joint venture. In some states, the AG may allow the parties to commence the review process with a letter of intent, as opposed to a definitive agreement. In a joint venture structure, the AG oftentimes requests the operating agreement of the joint venture. Other documents may include management services agreements, stock option agreements, profit-sharing agreements, employment agreements, and severance agreements.

d. Financial information of the parties: The application may require audited financial statements, business projection data, future earnings information, capital asset valuation, ownership records, fiduciary accounts, and other financial information of the parties.

e. Tax-related information: Tax-related information, such as any tax-free debt subject to redemption and any tax liability that may arise as a result of the transaction, may be requested by the AG.

f. Support for "fair market value": The AG will require evidence that the hospital assets are being sold at "fair market value." The parties may be required to (a) submit a fairness opinion, (b) engage a third-party consultant to perform a valuation of the hospital's assets, and/or (c) present an analysis of the bidding process and how such process resulted in a determination of fair market value. The determination of fair market value is not an exact science and, therefore, there is some flexibility as to the indications required. In addition, typically the AG understands that the selection of the winning bidder involves numerous factors beyond simply the highest proposed purchase price.

g. Summary of post-transaction commitments: The AG has a vested interest in ensuring that the hospital assets will continue to be used to provide quality health care to the community following the transaction. The AG typically requires that the buyer or the resulting joint venture continue to provide the core services currently provided by the hospital and adopt the indigent care policy of the hospital. In

some cases, the AG requires commitments by the buyer or the joint venture not to sell the hospital for a set period of time or to offer a right of first refusal to the seller in the event that a sale of the hospital is contemplated. The AG also will require assurances from the buyer/partner as to its ability to satisfy any capital commitments required by the definitive agreement.

h. Use of proceeds: The AG oftentimes requires particular disclosures relating to the use of the proceeds from the transaction. The AG will want to understand whether a newly created foundation or other 501(c)(3) organization(s) will hold the proceeds. The AG also will request information regarding how the proceeds will be used, such as to fund free health clinics, health screenings, health education, or other community needs.

3. Public Hearing and Public Comment Period

In states that have statutes addressing hospital conversions, a public hearing often is mandated as part of the AG review process. The AG also may independently require a public hearing or a public comment period. Prior to this, the AG or the hospital will provide a notice of the hearing. Typically, at the hearing, representatives of the hospital and the buyer/partner will make a presentation of the proposed transaction and answer questions from the community. In preparation of the hearing, the parties should consider identifying advocates from the community to attend the hearing in support of the transaction, and also anticipate and plan for any negative feedback or objections.

4. Public Disclosure of Transaction Terms

The parties may request that the AG maintain the confidentiality of the application and the terms contained in the documents, and perform his/her review of the documents "in camera"; however, state statutes, the Freedom of Information Act, or the AG may require that certain transaction documents be made available to the public. While the parties typically enter into a confidentiality agreement protecting

the disclosure of the terms of the transaction, a full disclosure or partial disclosure of the documents may still be mandated. In such instance, the parties may propose to the AG that the documents be redacted to protect confidential or competitively sensitive information, or for other exempt purposes. Notably, if the AG allows redactions, then parties generally must identify the specific basis upon which such information constitutes confidential or competitively sensitive information or is otherwise exempt from disclosure.

5. Third-Party Involvement and Approval

In some states, AG approval is contingent on the approval of a court and/or state agencies, such as departments of health and departments of insurance. This calls for added diligent coordination and effective communication among the parties. The AG also may condition its decision on the actual receipt of the approval by one or more third parties; thus, the parties should carefully manage timing and expectations. Additionally, open communication with and sensitivities towards other key constituents and advocates in the community, such as hospital associations, may be imperative for a successful application.

6. Post-Closing Covenants and Monitoring

Upon completion of the review, the AG may (1) issue a letter of no objection, (2) seek to void the transaction, or (3) take other appropriate action.

If the AG issues a letter of no objection, the AG may exercise post-transaction oversight to ensure that the parties are fulfilling the commitments and covenants that the parties agreed to during the conversion process. More specifically, the AG may impose post-transaction monitoring through the requirement of periodic reports to the AG's office, the legacy foundation, or a third-party monitoring body of certain terms of the transaction, including the level of indigent care spending, continuation of core services, and fulfillment of capital commitments. In some states, the AG also will stipulate that AG

approval or notification is required for any future changes in the ownership structure of the buyer or the joint venture and/or any future amendments to certain terms of the definitive agreement. These terms may include indigent care commitments, capital commitments, elimination or expansion of services, physician recruitment commitments, and any restrictions on further transfers of the hospital.

Key Elements to a Successful Conversion

Non-profit hospitals should be prepared to "defend" the decision to alter the tax-exempt status of the hospital to employees, medical staff, community members (including patients), local government leaders, interested advocacy groups, and the AG. A successful campaign rests on the extent to which the hospital's governing board and its advisors and the buyer or strategic partner can positively articulate the benefits of the conversion. Below are some key elements to a successful conversion:

1. Adequately document the hospital's strategic needs and objectives, as well as the business case for the transaction from the beginning of the process.
2. Act in a manner that is consistent with the fiduciary responsibilities and free from self-interest. The hospital's governing board members with conflicts of interest disclose the conflicts to the governing board (and ultimately, to the AG) and only vote on the proposal so long as they can fulfill the duty of loyalty. In our experience, it is best that the hospital board members recuse themselves when conflicts of interest arise.
3. Implement a comprehensive, rigorous, objective, and competitive process in the search for a buyer/partner. It is paramount to present evidence that multiple potential buyers/partners (typically, approximately 15 to 30) were contacted and alternate ownership forms were considered. Bilateral processes that fail to "clear the market" generally are not acceptable. A recent example of this is the Jameson/UPMC transaction in Pennsylvania (which was conducted on a bilateral basis), where the Pennsylvania Attorney

General did not believe the hospital governing board exhausted its duty to consider competing proposals and challenged the transaction.

4. Demonstrate that "fair market value" was achieved through the market-clearing process. Hospital enterprises contain tens or hundreds of millions of dollars of value. Securing this value for the community rests in the proper execution of a transaction. Hospitals often are required to produce written analyses comparing the range of offers received, their level of economic consideration, and the efforts used to maximize terms and conditions. Note that fair market value is impossible to assess without the input of alternative offers. Common sense, as well as the more formal 1985 Delaware case law *Smith v. Van Gorkom*, often called the "Trans Union" case, dictates that the hallmark of good decision making is having a basis of comparison.
5. Rigorously consider and address the financial and nonfinancial interests and issues important to the community and affected stakeholder groups throughout the process, including the AG application and public hearings. Here the "purchase price" is far from the dominant figure. Typically, legally-binding commitments to deploy capital in the community to construct new facilities or otherwise further the mission of the hospital, retain existing employees, create new job opportunities, recruit additional doctors and expand service lines to stem patient outmigration, improve the quality of services provided, and exhibit a growth orientation are well received by the community. The AG will assess if the transaction is in the public's best interest and may condition their approval on certain commitments from the buyer/partner that are designed to better serve the public's interest.
6. Commit any cash proceeds for the community's benefit. The duty of obedience requires hospital governing board members to be faithful to the charitable mission and purposes of the non-profit hospital. Typically, the conversion proceeds are directed to a private grant making foundation qualified for tax-exempt status under Section 501(c)(3) of the Internal Revenue Code or other

charitable organizations. Post-transaction, the foundation or the charitable organization with the conversion proceeds must be separate and act independently from the hospital (which will be a for-profit entity). Additionally, the funds must usually be spent in furtherance of the original charitable missions of the hospital, i.e., health care-related purposes.

7. Act in a transparent and honest way with competitors, lenders and payors.

Summary and Takeaways

The attorney general approval process in hospital conversions can be complicated and varies across states. This article outlines the process and ways in which a hospital can prepare for the many steps to the process. Like most things, experience is important—both for the AG and those applying for approval. As you or your client begin the conversion journey, consider the below:

- Seek out assistance from specialists—including legal counsel and financial advisors
- Dedicate sufficient resources to prepare the application, and more importantly, frame the story
- Follow a clear, rational, and transparent decision-making process
- Set realistic time expectations
- Maintain an open dialogue

Continuing a Non-Profit Hospital's Charitable Mission Through Mergers and Acquisitions

By Rex Burgdorfer and Ken Marlow

Business combinations between acute care non-profit hospital companies continue at a pace not seen since the 1990s. Participants are proactively entering the market for corporate control in an effort to forge partnerships that will position them to be successful in the future era of healthcare delivery.

This is not just a response to "Obamacare" or healthcare reform, but rather, critics say, is reflective of a system that delivers mediocre quality care at a high price, compared to other industrialized countries. Some cite the level of ownership fragmentation as one of the leading causes. Improving a hospital's root business fundamentals is more often the impetus for considering consolidation opportunities rather than the broader policy issue.

The 2000s were dominated by two trends: first "the bear hug" and second "the need for capital." "The bear hug" is a common phenomenon whereby small Hospital A prematurely arrives at the decision that it makes sense to combine with Hospital System B, usually the closest sizable partner. While this conclusion is a natural inclination of the board, experience has shown that such outcomes are less favorable to Hospital A than for Hospital System B. Absent a rigorous, competitive process, Hospital System B is in full control of the transaction flow. The board of Hospital A has no basis of comparison with which to test the terms and conditions. It is surprisingly common to see a number of hospitals that have "given themselves" away.

"The need for capital" is a catchall description for the straightforward trend of hospitals considering strategic alternatives from a weak, defensive position. Many companies in the 2000s waited too long to evaluate options, and therefore were forced to consider sales out of a necessity to raise capital. Very often these hospitals were located in economically depressed regions, had weak demographics, and an overdue need for capital (e.g., new bed tower, new emergency

department, etc.). Absent a stronger partner, future survivability was in question.

The 2010s saw the beginning formation of regional networks and the creation of substantial community foundations. First, studies have shown that successful hospital operations command large footprints of business scale. They also demand regional expertise that allows systems to participate in narrow networks and integrated physician plans. These types of networks enable the system to manage risk, employ physicians, share best practices, and coordinate the overall healthcare of a population.

The second trend pertaining to the creation of a substantial "community foundation" requires a more robust discussion.

The Creation of Substantial Community Foundations

Many believe that over the last 50 years, the hospital industry has shifted from a strictly charitable undertaking to a major industry that is capital intensive, regulated, complicated, and extremely inefficient. Systems considering strategic partnership opportunities are scarred by the past. They do not want to replicate the bear hug outcome where many of their peers "gave away" hospital businesses worth millions of dollars in value. They recognize the inherent value of the community asset they oversee and believe it is their fiduciary responsibility to maximize economic benefit. In particular, many seek to create a fund to further the healthcare mission that the community sponsored for decades.

Community healthcare foundations can be created or enhanced in a hospital merger and acquisition transaction in one of the following three ways.

Key Board Takeaways

Hospital business combinations continue at a pace not seen since the 1990s. The 2010s will likely be defined by the formation of regional networks and creation of community foundations. Community foundations can be created or enhanced in a merger and acquisition transaction in one of the following ways:

- **Conversion transactions:** Generally this takes place when a non-profit organization that owns a hospital enters into an asset sale transaction with an investor-owned company and the hospital converts to for-profit status. The seller could remain in existence and use the sale proceeds in furtherance of its charitable purposes or, more commonly, transfer such proceeds to a community foundation.
- **Comingled foundations:** If the acquirer is a large non-profit system, the foundation affiliated with the non-profit seller can be managed as a subset of the parent company's foundation.
- **Retaining a separate foundation:** When two non-profit hospitals combine, often they elect to retain separate foundations. In this instance, the bylaws of the seller are typically redrafted to acknowledge the new partner as the primary beneficiary of the philanthropy.

1. Conversion Transactions

Generally, a conversion transaction takes place when a non-profit organization that owns a hospital enters into an asset sale transaction with an investor-owned company and the hospital converts to for-profit status. The seller non-profit organization could remain in existence and use the sale proceeds in continued furtherance of its charitable purposes or, more commonly, transfer such proceeds to a community foundation. The cash purchase price, plus retained assets, less the cost to retire all liabilities (including pension plans) and fund escrows, yields the proceeds to the seller non-profit organization that can then be transferred into a foundation. Funds can either be transferred into an existing foundation affiliated with the seller or to a newly created foundation. Non-profit hospital organizations should have an understanding of the state laws governing such hospital conversions. Many states attorneys general conduct a thorough process to ensure that charitable assets (i.e., sale proceeds) transferred to the foundation remain with the foundation and are used exclusively for the predetermined charitable purposes.

Limitations surrounding the use of the money depend on the type of seller. If the seller is a religious organization, the sale proceeds are commonly redeployed within the church (e.g., to care for aging clergy members). If the seller is a local government organization, sale

proceeds are often redirected within the municipality (e.g., to fund education or infrastructure initiatives). If the seller is a traditional section 501(c)(3) non-profit organization, the sale proceeds must be directed toward causes in support of the original charitable purposes of the organization or, if transferred to a foundation, the charitable purposes of the foundation. Generally, the mission and charitable purposes of the non-profit organization and affiliated foundation are healthcare related. Money cannot be used to (a) pursue wholly unrelated businesses or projects, or (b) inure to the benefit of the owner of the now for-profit hospital. Common acceptable uses include making grants to support community healthcare projects, operating community clinics, financing nursing scholarships for area residents, establishing healthy eating programs in schools, supporting vaccination programs, etc.

After the sale, the foundation cannot generally transfer any funds to the for-profit hospital or participate in its operations (i.e., purchase equipment, supplies, etc.). An exception exists when the transaction is structured as a hospital joint venture and the non-profit owner or its foundation continues to hold an interest in the hospital through the joint venture. In this case, so long as the transfer of the hospital to the joint venture is made at fair market value and proportionate to the ownership percentage, it is characterized as an "investment" and participation in hospital operations is permissible. It is important that the hospital joint venture be structured in a manner that meets the requirements set forth by the IRS for hospital joint ventures (including furthering charitable purposes, meeting community benefit and 501(r) rules, governance control rights, etc.), so that the non-profit partner can maintain its section 501(c)(3) tax-exempt status.

2. Comingled Foundations

If the acquiror is a large non-profit system, the foundation affiliated with the non-profit seller can be managed as a subset of the parent company's foundation. For example, Juniper advised on a transaction in which the seller's foundation contained roughly $10 million. Following the implementation of a competitive process to evaluate strategic alternatives, the seller elected to become part of a large, well-known strategic partner. The transaction contained the assumption of

financial liabilities and capital commitments, but not a purchase price. The acquiring system is the beneficiary of a tremendous level of philanthropy and manages in excess of several hundred million dollars. As one would expect, they hold well-developed legal, accounting, and investment management capabilities. In this case, the seller sought to preserve the use of its foundation locally but tapped into this expertise by comingling and pooling its funds with the much larger foundation of the new partner.

3. Retaining a Separate Foundation

When two non-profit hospitals combine, often they elect to retain separate foundations. In this instance, the bylaws of the seller are typically redrafted to acknowledge the new partner as the primary beneficiary of the philanthropy. A competitive process should produce terms that allow the selling foundation to retain its existing assets and even add to the foundation's capital with excess cash reserves from the hospital's balance sheet. It is important to ensure that the buyer's financial commitments or future capital allocation policies are not predicated on achieving or maintaining any sort of financial metric. One can see that if current cash assets are transferred, then liquidity ratios will deteriorate. This, obviously, should not harm the pecking order of system capital allocation going forward. The drawback to this strategy is that the smaller foundation pays a comparatively greater amount than the larger foundation for management, annual filings, and other costs of operations.

Final Thought

While a charitable community foundation might not fit the needs of all participants in hospital combinations, the creation of foundations is receiving increased attention in the market. More than anything, this seems to be indicative of the level of change occurring at modern hospital companies. Community-minded boards often want to enhance the work of their predecessors, continuing the legacy of the local hospital mission.

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Do Hospital Affiliations Risk Becoming the Next Brexit?

By Rex Burgdorfer and Jordan Shields

The European Union is an affiliation. Unlike a federal government, the United States for example, where members combine into a single sovereign nation, each member state of the EU remains independent. The EU member countries gain a measure of collective strength and influence by ceding control over certain decisions, regulations and institutions to a central authority, but they remain sovereign and free to exit.

Sound familiar? This is the same type of arrangement as hospital affiliations.

Over the last several years, hospitals have rapidly formed collaborative regional partnerships. These relationships are designed to address challenges that small systems and independent hospitals are ill-equipped to efficiently navigate on their own. Hospital affiliations include accountable care, population health, purchasing, information technology, academic, management and many other agreements. In consulting presentations and at conferences, community hospitals are encouraged to pursue affiliations rather than fully combine to realize the benefits of scale without ceding ownership or control. As Britain's vote to leave the EU, or Brexit, showed us last week, this argument is a dangerous fallacy. By definition, affiliations require participants to cede control, either to the collective (accountable care agreements) or to another party (IT and management agreements).

The problem with affiliations is that their greatest selling point "sovereignty" is also their greatest weakness. Affiliations do exactly what they are set up to do, they work until they don't. The often-overlooked truth is that when they come to an end, organizations and countries typically find themselves worse off than before they entered

the partnership.

It is no surprise when affiliations end - if they were not intended to be temporal, the parties would cede sovereignty to gain the enhanced stability and the benefits of full integration. More often than not, affiliations end when money becomes an issue. In Britain, it was how disillusioned workers who felt left behind perceived the EU's immigration policies. With hospitals, these points of friction include disputes over where high margin cases go in clinical affiliations, fair sharing of preventive medicine costs in accountable care organizations, disagreements over where to invest capital or place centers of excellence in joint operating agreements, and disputes over implementing or deferring the latest system upgrade in IT affiliations, among many, many other questions. The objectives of independent companies change and diverge over time. When that happens, the affiliation unwinds.

Unfortunately for both Britain and the remaining members of the EU, the dissolution of health system affiliations that we have worked on indicate that all parties are in for a rough ride. Hospital systems that leave face the immediate challenges of backfilling corporate resources, contracts and clinical relationships while attempting to restore stability. We see this playing out in parallel for Britain.

What does this mean for the organizations that remain in the affiliation? Those that stay typically don't stay for long. Affiliations draw their strength from scale. As they begin to shrink, the benefits of staying shrink while risks grow. Those that linger (Germany) bear responsibility for the weak (Greece). The strongest participants (Britain) tend to leave first, because they can, and the remaining block ends up with less to offer, so the next tier of participants completed their own cost-benefit analysis and are much more likely to leave. Unfortunately for those participants (Italy or France) they tend to be even less prepared for their departures than those that were out the door first. The last to leave are left cleaning up the mess. This incentive causes a 'run on the bank' once initiated.

Finally, the Brexit saga has the potential to inform non-profit hospital leaders about the ability to reconstitute oneself following divisions. Unlike large sophisticated countries that can go back to being independent, hospitals rarely have that luxury. Once part of an affiliation, it is extremely difficult to 'unscramble the egg' or 'put Humpty Dumpty back together.' Such realities can force an emergency sale out of distress, eroding value and forego the potential to achieve favorable terms. The best partnerships are entered into based on careful consideration of alternatives with a decades-long view. Being forced to quickly find an alternative or new partner as an affiliation pulls apart results in poor decision-making and lost value for the community.

This same phenomenon of centralization is true in the non-profit hospital world. Full-scale change-of-control transactions are infinitely more difficult to create but have proven to be more powerful and permanent. The ability of a combined entity to affect positive change is much greater when owned, controlled and operated as one.

This lack of durability comes with costs. History has shown that groups that take the more difficult leap upfront of fully combining (e.g., by pursuing a merger, sale or consolidation) fare better in the long run compared to those that dip their toes in ready to pull them out at the first sign of trouble.

Witness the success of the United States in the post-WWI era. While extremely difficult to form (the Revolutionary War, Civil War), the United States' economy took off when it completed its interstate highway system and knocked down the final vestiges of interstate tariffs and frictions. Similar success stories exist within vertically integrated and centrally governed healthcare companies.

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What Today's Hospitals Can Learn from Downton Abbey

By Rex Burgdorfer and Jordan Shields

In its final season, "Downton Abbey" captured audiences by exploring a healthcare phenomenon set in rural England 100 years ago — and one still playing out across America today.

The phenomenon is hospital consolidation, and historical period drama "Downton Abbey" tackled it with the same gusto with which it took on the deterioration of class hierarchies, the emergence of the women's liberation movement and many other social issues over six critically acclaimed TV seasons.

At the beginning of the 20th century, hospitals in both England and America were much different places than they are today. They offered basic nursing services to keep patients as comfortable as possible and not much more. These institutions were most typically standalone facilities largely underwritten by local philanthropists. During this period, modern medicine began to take hold. Sophisticated organizations, often associated with universities and generally in urban areas, began to adopt new 'technologies' like operating rooms, pathology, electrocardiograms, X-rays and others. These advances changed the nature of hospitals and healthcare. Hospitals shifted from warehouses for recovery, and often decline, to early examples of what hospitals became in the late 20th century.

In the same way "Downton Abbey" had asked questions like, "Why is Mr. Carson, the head butler, so eager to perpetuate class roles?" and, "How would Lord Crawley, the conservative patriarch, react to his daughter's liberal political activities?" the show asks:

"Why would a local community reject modern medicine?"

Over the course of "Downton Abbey's" final season, we learn the answer. There is a cost associated with modernizing the local hospital, and it is not primarily economic. The cost is control.

Modernizing the hospital requires the clinical and scale resources of a partner. To capture those benefits, the town's parochial elites, who built the hospital and have overseen its delivery of nursing care for years, would need to cede some of their absolute control over the endeavor. As Maggie Smith's character states, "less control … is what I consider my duty to resist."

Efficiency, access to treatments, medical staff advancements and other scale benefits are seen as acceptable casualties relative to "diminishing [the board's] own importance." To overcome this resistance to change, "Downton Abbey's" proponents of progress work to frame the argument and place the healthcare of the community above the personal, societal and historic concerns of the few. Maggie Smith's character's group on the hospital board is content exerting its "control" to maintain the status quo. Unfortunately, that status quo places the healthcare of their community at risk.

To counter this, those that recognize the benefits of medical advancement work to reframe the debate. They question whether "local control" should be the goal, or whether the board has a broader mandate than self-perpetuation. This cohort says the primary question is which system is more likely to deliver modern treatment to the local population — not which system is more likely to maintain their historic positions.

The reason "Downton Abbey" enjoyed so much popular success is that the issues the show confronted are as applicable today as they were 100 years ago. The choices today are not between nursing-only facilities and hospitals with X-rays, but the tension between control and scale is very definitely still relevant.

From the Roaring Twenties to the 2010s

We have dedicated our careers to advising hospital boards on transactions. We spend our time in hospital boardrooms across the country addressing the exact issue confronted by "Downton Abbey" — how can hospital boards best meet the healthcare needs of their communities and support the institutions to which they have donated so much

time and energy?

Our clients, like the board portrayed on "Downton Abbey," are concerned with how change will impact their communities. They recognize that without scale, things important to them like quality, consistency, outcomes and efficiency can be more than just expensive — they can be illusory.

If the tension 100 years ago was between standalone nursing beds and facilities with X-rays and ORs, the tension today is between standalone hospitals and small systems struggling to make the shift from fee-for-service to population health and organizations with the infrastructure in place to keep patients out of the hospital by driving quality, efficiency and consistency.

What strikes us 4,000 miles away and a century after the "Downton Abbey" story is how human these struggles are. Today's non-profit hospital boards, typically consisting of very well-meaning volunteers, face the same existential question that their counterparts on "Downton Abbey" and community boards faced after the turn of the last century: How do we best adapt to changing times to ensure the highest quality, most efficient care for the communities we serve?

What we have learned in our work across the country is what "Downton Abbey" so deftly demonstrated in its final season: These decisions are best made through thoughtful spirited debate that is grounded in actionable information and alternatives.

This article was originally published by Becker's Hospital Review.

Editors' Note: We have chosen to include this article from 2013 as a past perspective on how multistate systems were being anticipated. It should be read with Barry Sagraves' second article on the topic which follows.

Multi-State Non-Profit Health Systems: Why There Are Not More, but Soon Will Be

By Barry Sagraves

After several years of enthusiastic merging and acquiring, multi-hospital systems now own approximately 70 percent of all U.S. hospitals not owned by a government entity. There are more than 400 systems, of which over two-thirds are secular non-profit systems. However, unlike their religious and investor-owned counterparts, almost all of these systems have remained small and local. In an era where scale seems to be more important than ever, these 284 secular non-profit systems average only five hospitals per system, and boast only five systems that can be argued to be significantly active in more than one state.

Are these small, local non-profit systems anomalous dinosaurs, destined to be swallowed up by larger systems, or simply to wither away? Or are they financially and (maybe more importantly) culturally able to change their focus and join the game everyone else is playing? Will they be able to form larger, financially strong systems to rival those already extant, and which are themselves increasingly merging into ever-larger competitors?

The hospital industry is uniquely structured among U.S. industries, particularly in its complete lack of dominant players. HCA, the largest system, has less than a 5 percent market share by number of hospitals. Typically, large industries have three or so dominant players and several niche ones; the hospital industry has nothing but niche players.

A big reason for this is that a large segment of the industry is made up of individual community non-profit hospitals that have not historically wanted or needed to either form or join a system.

The historical roots of these organizations largely explain why they have not banded together into large, efficient multi-state systems, and those who have combined have typically done so locally.

Whether these small, local systems will aggressively seek to combine into larger, multistate systems has major implications for the future shape of the hospital industry, the viability of population health as envisioned by the Affordable Care Act (ACA), the $3.7 trillion municipal bond industry, and, of course, the strategies and ultimate success or failure of the individual systems themselves.

Past Obstacles to Multi-State Non-Profit Systems

It is relatively straightforward to explain the lack of multi-state non-profit systems, yet worth recounting in order to assess the likelihood of them becoming a significant feature of the industry in the future. The main reasons for the local nature of these systems include:

- **Local mission.** The vast majority of independent non-profit hospitals were founded by members of the local community, often with a bequest from a prominent family. The purpose of such hospitals—often required by the founding gifts—was local care. Even when some such hospitals evolved into multi-hospital systems, their focuses have remained on their local region rather than expanding into other states—this just hasn't been seen as part of their mission.
- **Municipal finance.** Municipal bonds have been by far the dominant means of financing non-profit hospitals' capital needs. Traditionally, bonds were issued by conduit agencies in each state, and bought largely by local individuals. Financing capital projects through a number of different issuers in different states was relatively costly and inefficient.
- **Complexity.** Each state has its own programs (notably Medicaid), legal regime, payor landscape, and politics; it is simply more complicated to operate in multiple states. Lacking size and influence,

many organizations have found it better to remain in their own home area.

- **Charitable trust law.** States' charitable trust laws governing non-profit assets have inhibited some interstate transactions and movement of assets, even among non-profit partners.

Out of these obstacles, the most significant one has probably been the organizations' sense of their own missions; some of the other obstacles have diminished significantly over recent years.

Both religious and investor-owned systems, by contrast, have had compelling reasons to spread across wide geographies. Many religious systems were laid out, literally, along wagon train and railroad routes, often as congregations of religious sisters were asked to provide care in newly settled parts of the West. These institutions often predated the founding of secular non-profit hospitals as described above, resulting in many of today's remaining two-hospital towns.

The growth of investor-owned systems has been no less intentional. All investor-owned companies have an imperative to grow, and many have sought geographic diversification in order to mitigate risks of Medicaid funding and structure, economic base, and political attitudes toward for-profit healthcare.

Current Multi-State Non-profit Health Systems

In our survey of non-profit systems, we identified only five secular non-profit systems in the country that could be considered truly multi-state systems (and even these five could be debated). These comprise 119, or 7.5 percent, of all secular non-profit system hospitals (see Table 1). In an industry that, as described above, already has a highly unusual structure, this lack of aggregation by even successful secular non-profit systems is perhaps the most extraordinary aspect of that structure.

Table 1: Five Multi-State Health Systems

System	Location	Revenue	Hospitals (Owned)	States	Formation
Banner Health	Phoenix, AZ	$4.7b	23(22)	AK=1, AZ=12, CA=1, CO=4, NE=1, NV=1, WY=3	1999 merger, Samaritan Health Services and Lutheran Health System
Carolinas HealthCare System	Charlotte, NC	$4.4b	23(12)	NC=19, SC=4	Organic, founded 1940
Essentia Health	Duluth, MN	$1.6b	15(15)	MN=10, WI=1, ND=1, ID=3	2004 Benedictine HS and SMDC HS; 2008 Innovis; 2010 Brainerd Lakes HS
Mayo Clinic Health System	Rochester, MN	$8.8b	25(23)	AZ=1, FL=1, GA=1, IA=2, MN=13, WI=7	Organic, clinic founded 1892. System formed 1992
Sanford Health	Sioux Falls, SD	$2.5b	33(23)	IA=3, MN=16, ND=5, SD=9	2009 merger, MeritCare Health System and Sanford Health

Source: American Hospital Association.

There are a number of other systems that have made incursions across state lines, such as UnityPoint Health and ProMedica, but such systems so far are not major players in their secondary state markets.

So, what features do these five systems possess that have provided the basis for their unique geographic presence? And what lessons can other systems learn from them that may lead to further combinations of secular non-profit systems?

First, and most obviously, all but Carolinas (which serves primarily Charlotte and its referral catchment area) serve rural areas to a significant degree rather than major metro markets. Indeed, Essentia, Mayo, and Sanford all serve the same region, the Dakotas and Minnesota. While Banner is tilted heavily toward the Phoenix market, the legacy Lutheran markets are rural and widely scattered.

Second, Banner, Essentia, and Sanford were the result of mergers between existing systems in different states. Two of the three systems forming Essentia are Catholic, but the inclusion of the secular Innovis Health in 2008 makes it worthy of consideration as a multi-state system. Carolinas and Mayo appear to have taken similar paths to their present configurations. Each has absorbed smaller, stand-alone rural hospitals to create referral networks to their tertiary hubs. Indeed, Carolinas has "absorbed" its four South Carolina hospitals by contract-managing, rather than acquiring, them.

So, the common attributes of current multi-state secular non-profit systems would appear to be:

- Result from mergers of relatively similar-sized systems
- Serve a largely rural population
- Employ a range of transaction structures (purchase, lease, manage)
- Are relatively static once formed (i.e., don't then spin off markets that don't "fit")

But are these systems models or outliers? Most systems do not have the brand name of Mayo. Many do not serve primarily rural

populations. Almost none have received major gifts from a wealthy benefactor, as Sanford has.

Why More Are Coming

The dynamics set in motion by the ACA will likely result in a dramatic increase in the number and size of secular multi-state nonprofit systems over the next 10 years. Like most trends, this will begin slowly, then accelerate until a number of these organizations rival in scale those in the investor-owned and Catholic sectors.

Chief among these drivers are the desire for scale and the need to serve ever-larger populations. As investor-owned companies accelerate their consolidation (CHS and HMA, Tenet and Vanguard), mergers such as Catholic Health East with Trinity Health are also dramatically reshaping the landscape and increasing the minimum size considered necessary for long-term success. While most population health efforts to date are within individual states, these will broaden out, and direct-contracted, narrow network products with large employers will require coverage wherever the employer is.

Growth across state lines is also being facilitated by changes in the financing of capital projects. Not only are more municipal bond conduits able to issue bonds across state lines, the ever-increasing presence of institutional investors has created a preference for larger, more-diverse issues. The days of the local, stand-alone $50 million muni issue are not gone, but they are surely numbered. Additionally, increasing use of taxable and nonasset-based financing will further lessen the ties to locality.

While the ACA is changing many aspects of healthcare funding, there remain benefits to diversification across multiple states. The range of exchanges and insurance markets across states will achieve varying degrees of success, and for many states Medicaid funding remains a challenge. Many systems in Illinois, for example, gaze fondly and rather jealously at their neighbors in Indiana and Wisconsin, whose Medicaid systems are much more generous to providers.

New organizational and transaction structures are enabling non-profit systems to expand across state lines more effectively than they have previously. Chief among these is the recent penchant of non-profit systems to joint venture with investor-owned companies to facilitate expansion as well as add management or clinical expertise. Duke LifePoint, Aurora IASIS, and the Cleveland Clinic's affiliation with Community Health Systems are examples of non-profits partnering to expand beyond their traditional local bases. While these have so far resulted in one-off acquisitions, it would be a small step to expand the structure to facilitate system-to-system mergers.

Finally, there are increasing numbers of systems banding together for specific purposes, which may foretell a future merger. For example, there are a number of instances of non-profit systems in adjoining states collaborating on a unified managed care/population health strategy. If they partner effectively on the payor side, logic would suggest that a merger among the providers might be in the cards at some point.

Will this happen? The imperatives of growth and diversification are compelling in favor of a significant increase in large non-profit systems. Previous barriers, particularly relating to financing, are rapidly declining in importance. Attorneys general continue to play a key, and varied, role in transactions of all types (witness the opposition to Sanford's merger with Fairview in Minnesota this past spring), but law and policy are likely to evolve over time.

Probably the largest remaining obstacle is the continuing sense of local mission. Having been founded locally, and usually still with local leaders on the boards, expansion within the home region is typically as much as seems appropriate for these systems. This is not a lack of vision, just a vision that has evolved in a sensible, linear path over time. Yet the discontinuities and challenges of the current environment may render this linear path ineffective, if not dangerous.

The trajectory of the hospital industry will encourage further consolidation. As independent community hospitals are joining systems in the current phase of this process, systems themselves will

amalgamate in the next. Catholic and investor-owned systems are well attuned to this and are actively engaged in the process. Forward-thinking secular non-profit systems would be well advised to take out their atlases and see if there isn't an appealing partner in an adjoining state.

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Multistate Systems on Their Way at Last

By Barry Sagraves

In the early 2010s, we wrote an article for The Governance Institute predicting that there would be an increasing number of health system mergers across state lines, creating new multi-state, super-regional systems that would have the benefits of scale, and not just size. We pointed out that there were at that time only about five non-profit, non-Catholic systems formed in that way, and detailed the historical impediments to such developments. The systems we identified as meeting these criteria were Banner Health, Carolinas HealthCare System, Essentia Health, Mayo Clinic Health System, and Sanford Health.

We boldly predicted there would soon be many more cross-border combinations across the country—using the term "soon" advisedly, as change is usually slow in such a fragmented, conservative, and highly regulated industry. There have been few such transactions in this period; however, the conditions are increasingly ripe for these deals. In this article, we describe why this is the case, and double down on our prediction that such combinations will in fact begin to occur—soon.

Thar She Blows! A Textbook Example of This Trend

The recently completed combination of Advocate Health Care of Chicago and Aurora Health Care of Milwaukee is an example of this kind of transaction. They are of almost equal size, serve contiguous geographies, and have complementary areas of expertise. These systems also will gain size, but probably remain below the threshold where size becomes counterproductive.

The combined company will provide others contemplating such tie-ups with a number of criteria to consider when evaluating, negotiating, and structuring similar combinations. The key elements are:

- It is a "good-to-good" combination. The majority of transactions continue to involve a larger, stronger system taking on a smaller individual hospital or system. The "seller" typically has challenges of financial performance, capital access, or cost structure. Both Aurora and Advocate are successful, reasonably large regional systems with good positions in their markets. It is a more appealing task to make strong organizations stronger than to forge a turnaround of one of the partners.
- The "industrial logic" is strong. The service areas are not only directly contiguous but are converging economically. As more businesses and residents move out of Illinois into southern Wisconsin, a health system that can cover both areas should find significant growth. In addition, both organizations are committed to physician integration, population health, and risk-bearing, so there is strong strategic alignment.
- They "punted" on just enough social issues. The key impediment to combinations such as this are the social issues of management control and board composition. Many such discussions fail to gain traction over who gets to be CEO and the number of board seats each organization will fill. In this case, the parties agreed to co-CEOs, dual headquarters, equal board seats, and rotating chairmanships. None of these "fudges" is efficient, or long term, but they help to "get the deal done," which makes business sense.

Why Haven't There Been More?

There are a number of reasons why this multi-state trend has been slower to take off than expected. One, as mentioned above, is simply the nature of the industry: fragmented, conservative, and highly regulated. Many attorneys general remain concerned about the possibility of charitable assets being moved or controlled by an out-of-state entity, and the social issues of management and control remain as potent as ever.

This is in a context of the overall number of transactions being down somewhat from its recent peak in 2015. While activity is still brisk, the individual hospital market is presently tilted toward systems filling out local markets with acquisitions or sellers with financial challenges or capital needs.

There are several reasons that transaction activity has declined among individual hospitals:

- Margins are up. While it is somewhat challenging to identify a large number of individual hospitals that are more profitable than they were a few years ago, aggregate figures indicate that the average operating margin of hospitals has increased slightly over the past several years. This is primarily due to reduced bad debt thanks to Medicaid expansion. With less imminent financial distress, individual hospitals are less likely to need to find a partner.
- There are fewer buyers. Consolidation among investor-owned systems as well as Catholic systems have occupied their time and resources, as well as reducing the number of buyers.
- Turnarounds are harder. It is becoming easier and faster for a hospital to fail. Losing a key contract, a sudden change in reimbursement, or similar events have led to discontinuous drops in performance, and systems are increasingly unwilling to take on these situations.
- Many geographic markets have become largely consolidated

Future Growth of Multi-State Transactions

The patterns above, which tend to depress partnering of individual hospitals, should accelerate the trend of system-to-system consolidation. As mid-size systems seek growth and meaningful scale, the most effective way to achieve this will be system combinations, and these will include those across state lines.

The overall industry drivers will only intensify. The limits of Medicaid expansion are in sight as funding responsibility shifts back to the states, changes toward population health, and increasing competition from disruptors (e.g., CVS-Aetna, Berkshire/JPMorgan

Chase/Amazon) will maintain pressure to reduce costs as well as develop new capabilities and business models. Finally, as individual markets reach a consolidated equilibrium, further growth will have to come from combining with organizations in other, preferably contiguous, markets.

Most of the system mergers to date have arguably been more about size than scale. *Size* connotes the ability to buy in bulk, to centralize some functions and spread overhead. *Scale* adds the ability to operate more effectively as well as efficiently, improving an organization's ability to execute as the industry changes. This might be by combining skills or relevant markets that provide additional strategic or financial value. A number of studies have indicated that there is significant additional value created by the integration of partners over and above that derived from merely combining.

So, why will there be more multi-state mergers? To paraphrase the bank robber Willie Sutton, that's where the partners are. In many states, either the partners have consolidated or the remaining mergers would face antitrust issues. Thus, the availability of partners and the ability to gain approval will drive systems to look across state lines. The prime markets for this type of activity probably divide into two types: metropolitan areas spanning state lines and rural states where dominant systems either within or contiguous to would find scale benefits in addition to size alone.

Conclusion

Systems looking for significant growth will need to look at a range of transaction strategies. Adding additional hospitals, groups of physicians, and new services will generally be the basis of growth. But they should also consider whether there is a partner a bit further afield that might be able to help them vault to the next level of effectiveness and success.

We believe that the formation of Advocate Aurora Health Care is indicative of a trend that will accelerate in the coming years. There may

be a similar opportunity—or competitor—coming to your market, you guessed it, "soon".

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Provider Realignment Post-Pandemic

By Brian Fuller and Jordan Shields

The COVID-19 pandemic has accelerated changes in the hospital industry. While population health, the blurring of the lines between payers and providers and regional mega systems were all familiar concepts pre-COVID-19, the pandemic marked the tipping point where these elements will re-define industry structure.

History

To understand the trajectory of the industry and its historically slow pace of change, it is useful to look back at the overlapping history of population health, the payer-provider divide and the emergence of regional hospital systems.

Population Health: The prospective fee-for-service reimbursement model has been in decline nearly since its ascendancy in the mid-1980's. HMOs, Hillarycare, Obamacare and payment reform of all types have aimed at taking down a system that rewards excess utilization and inefficient (and often invisible) cross-subsidization. Despite accountable care organizations gaining momentum in the 2000s and providers beginning to take on risk, fee-for-service reimbursement firmly remains the fundamental force driving industry organization.

Blurring Distinctions Between Payers and Providers: At the same time, the traditional distinctions between payers and providers (i.e., financing and delivery) has shifted, if glacially slow, prior to the pandemic. To be clear, the distinctions between payers and providers are more a function of expedience than regulation, with Kaiser Permanente being perhaps the best example. At the height of the Great Depression, Dr. Sidney Garfield opened a field hospital to support the Colorado River Aqueduct. After struggling with collections, Dr. Garfield created a "prepayment" system, where he charged a nickel a day to cover job-related medical care and another nickel a day for non-job-

related care. He eventually teamed up with Henry Kaiser, the developer of the Grand Coulee Dam, and Kaiser Permanente was formed.

Over time, various models of capitation and risk sharing have come and gone. The most notorious example is Allegheny Health, Education, and Research Foundation (AHERF) which grew from a single Pittsburgh hospital to a Pennsylvania-wide health network insuring nearly a million lives before it collapsed in 1998 as the largest healthcare bankruptcy ever. This came full circle in 2013 when Highmark, a Pennsylvania Blue Cross carrier, acquired West Penn Allegheny.

Regional Mega Systems: Over the last 50 years, the proportion of hospitals in multi-hospital systems has gone from about 25% to about 65%. This is relatively modest consolidation, underlined by the fact that UnitedHealth Group's market share in the health insurance industry, as measured by direct premiums written, is equivalent in size to that of the five largest health systems: HCA, Kaiser, CommonSpirit, Ascension and Providence. Despite the slow movement, hospital systems have been consolidating in efforts to cut costs, improve quality and expand market coverage.

Pandemic's Impact on the Industry

While the full implications of the pandemic will take years to play out, it is already clear that population health, the graying of the line between payers and providers and the emergence of regional mega systems have all accelerated.

Population Health: The pandemic was notable for the variety of challenges it presented hospital providers. First and most notably was the non-essential services moratorium which de facto suspended most of the high-margin services at hospitals across the country regardless of the prevalence of COVID-19. Downward pressure on volumes was amplified by patients reluctant to seek treatment for reasons including worries of virus exposure and wide-spread reports of individuals viewing it as their civic duty to avoid care to free up hospital capacity. This phenomenon occurred even in markets that had

not been significantly impacted, and related to both procedures and diagnostic care. As colonoscopies and mammograms fell, so did the downstream follow-on diagnostics and procedures. Comparing to 2008's Great Recession, after which took three years for hospital revenues to recover from their 2009 depths, the impact from the current slowdown is expected to be more severe, given higher unemployment and accompanying (private and public) insurance market disruption.

What this all means for population health is that tightly integrated systems that had been taking risk were best positioned for the slow down. Capitated-style payments and insurance subsidies performed relatively well during the early months of the pandemic and integrated systems were able to better adapt to low density, non-acute services.

Payer-Providers: UnitedHealth's provider subsidiary, Optum, is growing faster than its insurance business. Optum employs more physicians than any hospital system, including Kaiser, in the U.S. But it is not just direct care that United and other insurance companies are seeking to dominate. They are seeking to exert greater control over all aspects of the health system revenue cycle, as evidenced by Boulder Community Health's July 2020 announcement that it was outsourcing all of its data, analytics, revenue cycle and care coordination services to Optum.

Regional Mega Systems: Growth in population health and new competition between payers and providers both underline how the center of the healthcare industry is shifting outside the four walls of the inpatient hospital room. More and more care is provided and sought in ambulatory settings. Many services that were unimaginable to consider providing outside the hospital, like total joint replacements, are now routinely done as outpatient surgeries, often with better outcomes. To remain relevant as their inpatient footprints shrink, hospital systems are growing vertically by adding services along the continuum of care, including home health, physician practices, skilled nursing, swing beds, hospice and others.

As these systems care for the patient in new environments, they are recognizing the scale efficiencies in expanding geographically. A notable pandemic-related example of this is Beaumont Health in eastern Michigan. Pre-pandemic, Beaumont had entered a definitive agreement to buy Akron, Ohio-based Summa Health System. Beaumont was severely impacted by the pandemic and made the quick decision that despite being the largest health system in Michigan, combining with Summa would not give it the financial or geographic scale that it needed to ensure success. The Beaumont board quickly pivoted, exiting its agreement with Summa and announcing a merger with Advocate-Aurora, one of the ten largest systems in the country. While Beaumont was certain to continue its growth in the absence of the pandemic, its decision to so quickly shift from working on building through acquisitions to joining an emerging mega system underlines how the pandemic has impacted thinking in the board rooms of some of the country's largest and most prestigious health systems. Over the coming years, we will continue to see an escalation in system growth – both geographically and vertically.

Implications and Approaches

The COVID-19 crisis exposed the fundamental fragility of U.S. healthcare. We paid a heavy price for fragmentation.

Looking forward, boards and executive teams will need to take action to keep their organizations relevant and healthy, including: 1) Evaluate the degree to which local and regional markets are integrating to compete on quality and efficiency; 2) Identify COVID-19 Era competitive differentiators and re-visit strategic plans to incorporate; and 3) Identify partnerships that will leverage organizational differentiators and support long-term success.

There will be no going back to the industry as it existed, only a going through to a more efficient, more dynamic and, in some cases and in some geographies, materially scaled healthcare system. Successfully approaching and navigating such a future will require healthcare leaders to ask and answer a number of important questions, including:

- Do we have the financial ability to survive the crisis and extended recovery?
- Can we articulate and fund a credible path to future growth?
- Can we continue to compete and succeed in an operating environment that advantages integration and scale?

Different organizations will have different answers to these questions. All should proceed based on their individual answers to them, and others that may be dictated by their markets.

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John provides strategic and legal advice on operational issues unique to health care companies, including the creation of business ventures and arrangements designed to address the changing needs of health systems in light of health reform legislation. He is actively involved in the creation of hospital service line management and branding

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John also has developed and executed cutting-edge legal and financing structures for the development of large capital projects, such as medical parks and proton therapy centers. He is recognized for his knowledge in developing and negotiating complex, multi-party contracts that document unusual or unique business relationships between the contracting parties. He also advises clients on corporate governance and compliance issues, and on wholesale reorganizations of corporate systems.

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Dave left a 28-year career in investment banking to create 4sight Health. As an investment banker, he managed over $30 billion in healthcare revenue bonds, led significant strategic advisory engagements for health systems. He specialized in capital formation, asset-liability management, enterprise risk analytics and new business-model development. Dave is also currently an investor and/or advisor for several early- or mid-stage healthcare companies including Curate Health, GaussSoft, HealthiPass, Link Capital, Medspeed and MultiScale Health Networks.

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Prior to joining Conifer, Jeff served as CEO for The JDJones Group LLC where he partnered with leading healthcare organizations, Fortune 500 companies, early-stage businesses and private equity firms as an advisor, partner, thought leader and change catalyst. Before The JDJones Group LLC, for over 20 years he held various senior executive and leadership roles with Huron Consulting Group and Stockamp & Associates.

Ken Marlow
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Healthcare companies growing strategically through acquisitions and joint ventures place their trust in Ken Marlow because he gets deals done. Ken has guided clients through more than 50 acute care hospital transactions with an aggregate value of more than $8 billion. Healthcare providers across the country have engaged Ken to form numerous joint ventures among hospitals, physicians and other healthcare providers. Ken also provides counsel to a publicly traded Fortune 500 healthcare company in strategic acquisitions across the post-acute care spectrum including skilled nursing facilities, rehabilitation hospitals, home health agencies and hospice care providers. Two recent transactions of note include the representation of a tax-

exempt health system in its 2017 merger with another 501(c)(3) healthcare organization in a transaction that created one of the country's largest not-for-profit health systems, and the representation of a financially troubled county-owned hospital in Pennsylvania in its acquisition by a privately held hospital management company based in Florida.

Additionally, Ken advises boards of directors and boards of trustees on corporate governance matters, including their fiduciary obligations and roles as trustees of charitable assets. He has also represented accountable care organizations approved by the Centers of Medicare and Medicaid Services under its Medicare shared savings program. In addition, he has served as counsel in more than 100 syndications of ambulatory surgery centers, dialysis centers and other outpatient facilities. Ken regularly speaks on a range of healthcare topics at national conferences, including The Governance Institute, Home Care 100 and the National Association for Home Care and Hospice.

Ken is the Chair of Waller's Healthcare Department which comprises more than 180 attorneys who focus their practices on various aspects of healthcare law and has been recognized nationally by Chambers USA. Ken is also recognized for his individual healthcare experience by Chambers USA, and his reputation within the healthcare industry led to his appointment to the Board of Directors of Leadership Health Care. Additionally, Ken was named a Health Care Hero by the Nashville Business Journal, and he has been quoted in the Wall Street Journal regarding hospital transactions. He is known for his ability to bring people and businesses together to structure, document and execute deals, and clients value his cooperative nature and team approach to overcoming complex issues. Ken currently serves on Waller's Board of Directors.

Stephen Morrisette
Associate Professor, Chicago Booth School of Business

Steve Morrissette's career includes large corporate experience in mergers & acquisitions and banking as well as entrepreneurial projects as an investor and founding CEO of several start-up businesses. In addition to 25 years of practitioner expertise, his academic career includes 12 years of full-time teaching and extensive scholarship on entrepreneurial finance including a comprehensive study of angel investors published in the Journal of Private Equity, numerous articles on the banking industry, as well as presentations and journal articles on M&A including a recent presentation on M&A at McKinsey's Corporate Finance Conference.

Most of his banking career focused on transformation projects, especially through mergers and acquisitions. His M&A experience includes over a dozen projects ranging from small deals with $10 million in sales to a full-time role on the First Chicago-BankOne executive merger integration team, one of the largest financial services mergers at that time. In his various CFO roles (BankOne Commercial Bank, American National Bank of Chicago, First Chicago Regional Bank), he was responsible for M&A and post-merger integration. When Jamie Dimon became CEO, he was asked to serve as head of Strategy & Planning for BankOne Commercial Banking. His M&A experience also includes selling business units, taking his firm public and eventually selling his first company 4 years after going public for a 450% return to investors.

Morrissette has extensive entrepreneurial experience -- he has been an angel investor actively involved in the formation of several firms in industries ranging from technology to plumbing parts. He was also the founding CEO of First Community Financial Partners, a bank group with 4 start-up banks having grown from zero to $1 billion in assets in just 7 years. At First Community, he led 5 stock offerings raising over $100 million in equity. As a consultant, his work includes business plan development, strategic planning, performance

improvement, turn-around management, management buyouts, and various types of M&A projects.

His academic credentials include a MBA with honors in Finance and Strategy from the University of Chicago and a PhD in Entrepreneurial Finance from Union University. In addition to Booth, he is an Associate Professor at the University of St. Francis in Joliet, IL and has guest lectured at the Northwestern Kellogg School of Management. His current research includes decision models for mergers and acquisitions including "A Framework for Validating and M&A Deal Thesis" published in the Journal of Accountancy and Finance. He also recently published "An Investor's Guide to Search Funds" in the Journal of Private Equity; the article was co-authored with a Booth student.

Alexandra Normington
Director of Communications, Juniper Advisory
Alex provides communications and marketing counsel to Juniper Advisory and their clients. She has an extensive background in health care communications, most recently serving as Director of Media for the Cook County Health & Hospitals System in Chicago. Alex also served as a Senior Advisor with Jarrard Phillips Cate & Hancock, a strategic health care communications firm, and as the Public Relations Manager for the Metropolitan Chicago Healthcare Council.

She earned a BA in Journalism from the University of Minnesota and an MPH from New York Medical College.

Michael Peregrine
Partner, McDermott, Will & Emery
Michael W. Peregrine represents corporations (and their officers and directors) in connection with governance, corporate structure, fiduciary duties, officer-director liability issues, charitable trust law and corporate alliances. Michael is recognized as one of the leading national practitioners in corporate governance law.

Michael is outside governance counsel to many prominent corporations, including hospitals and health systems, voluntary health organizations, social service agencies, colleges and universities, and health insurance companies. Clients seek Michael's counsel on matters relating to board conduct, structure, effectiveness, composition and controversy, as well as on internal and external/regulatory challenges to governance. He serves frequently as special counsel in connection with confidential internal board reviews and investigations. He regularly advises boards on complex business transactions, including more than 125 change-of-control transactions in his 37-year career.

Recently, Michael has served as lead transaction counsel in connection with a series of nationally prominent combinations of religious-sponsored health systems and large regional health systems/academic medical centers.

Michael is well known as a thought leader in corporate governance. He authors monthly columns on corporate governance for Corporate Counsel magazine and for publications of The Governance Institute. He is a regular contributor on corporate governance topics to The New York Times' "Deal Book" feature; Corporate Board Member, The Chronicle of Philanthropy; The Harvard Law School Forum on Corporate Governance and Financial Regulation; The Columbia Law School's Blog on Corporations and the Capital Markets, and the New York University School of Law Compliance and Enforcement Forum.

Michael is noted for his extensive experience advising non-profit corporations on matters of corporate law and governance. He authors a monthly publication, "Corporate Law and Governance Newsletter," and moderates a monthly director education podcast, "Governing Health."

Michael is a co-author of the three corporate governance compliance white papers published jointly by the Office of Inspector General (Department of Health and Human Services) and the American Health Lawyers Association.

Jeffrey M. Peterson
General Counsel, PSN Affiliates
Jeff built his practice with a focus on healthcare transactions, including acquisitions, divestitures, affiliations, joint ventures and other strategic transactions. Prior to joining McGuire Woods, he spent nearly four years at Tenet Healthcare Corporation, a diversified healthcare services company. At Tenet, Jeff facilitated numerous healthcare transactions in the acute care, outpatient, and physician practice spaces, as well as healthcare information technology transactions in the population health management and revenue cycle management services industries.

As in-house counsel embedded within the Acquisition and Development business team, Jeff gained a unique and deep understanding of the business aspects of healthcare transactions. He has a successful track record working on healthcare transactions of varying scale and complexity, from smaller outpatient and local community hospital acquisitions to complex joint ventures with national not-for-profit health systems. Partnering closely with business teams from initial review of prospective opportunities through post-closing integration, Jeff efficiently focuses his clients on the key issues and offers practical advice to successfully complete a deal.

Jeff earned a B.B.A. in accounting from The University of Texas at Austin. Upon graduation, Jeff worked at PricewaterhouseCoopers as an auditor and consultant. He returned to school to earn a J.D. from The University of Houston Law Center, where he served as managing editor of the Houston Journal of International Law and graduated magna cum laude. During law school, Jeff also became licensed as a certified public accountant in Texas.

Caitlin Podbielski
Associate, Vedder Price
Caitlin Podbielski is an Associate in the Chicago office of Vedder Price, where she regularly counsels a variety of clients on matters pertaining to state and federal tax exemption, state and federal privacy and

security laws, and health care regulation. She holds a BA from Xavier University and a JD from Loyola University Chicago.

Ethan Rii
Partner, Vedder Price
Ethan Rii is a Shareholder and Co-Chair of the Health Care & Professional Associations practice group in the Chicago office of Vedder Price. Rii focuses his practice on health care transactions and regulatory matters surrounding mergers and acquisitions, corporate restructurings and joint ventures for hospitals, health systems, multispecialty and large physician practices, specialty and ancillary care providers, managed care organizations, private equity firms and financial institutions investing in the health care space. He holds a BA from the University of Michigan and a JD from the University of Minnesota.

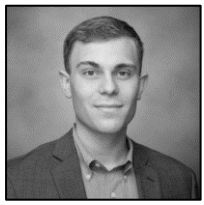
Megan Rooney
Partner, McDermott, Will & Emery
Megan R. Rooney focuses her practice on the representation of hospitals, health systems, and health care and life sciences companies. A former health care professional with firsthand clinical experience, Megan has unique insight into the business challenges and opportunities facing her clients. Throughout her tenure at the Firm, Megan has established a reputation as a service-oriented and experienced transactional attorney with more than 100 health care transactions to her credit. Clients seek Megan's counsel to lead large deal teams that drive efficient and effective outcomes and achieve business goals.

Megan has in-depth knowledge in all aspects of health care transactions, including mergers, acquisitions, affiliations, joint ventures and system restructurings for hospitals and health care providers. Megan regularly advises hospital and health system clients on regulatory compliance with respect to licensure, accreditation, and other state and federal regulatory matters, including disclosures to the Centers for Medicare & Medicaid Services pursuant to its Self-Referral Disclosure Program.

Megan served as an adjunct professor of law at Northwestern University School of Law for nearly a decade and has authored multiple publications on health care transactions. Megan is an active member of the Firm's Gender Diversity Committee, Associate Recruiting Committee and Internal Compliance & Reporting Committee. Megan is a two-time past co-chair of the Chicago Office Summer Associate Program.

Megan also co-leads the Firm's Hospitals and Health Systems Representation affinity group, which brings together McDermott lawyers from within and outside the Health Industry Advisory Practice Group to develop thought leadership, share information and collaborate on best practices.

Barry Sagraves
Managing Director, Juniper Advisory
Barry's healthcare experience has focused on merger and acquisition advice for non-profit hospitals, health systems and managed care providers. Barry was previously a managing director at Bury Street Capital, a financial advisory firm in London. He also held senior positions at Northern Trust and John Nuveen & Co. He holds an MBA from Kellogg School of Management at Northwestern University and a BA in Economics from Yale University.



Jeff Simnick
Senior Analyst, Kaiser Permanente
Jeff Simnick is a Senior Analyst with the Corporate Development team and joined Kaiser Permanente in 2016. Jeff assists the team with their growth, care delivery, and strategic planning functions by providing analytical support and project management.

Prior to Kaiser, Jeff worked for Juniper Advisory, a boutique investment bank that specializes in hospital and health system mergers and acquisitions. While there, Jeff provided deal support on a number of health system transactions around the country.

Jeff has a Bachelor's degree in Economics with a minor in Statistics from the University of Chicago and is a Certified Healthcare Financial Professional through the Healthcare Financial Management Association.

Isaac Squyres
Partner, Jarrard, Phillips, Cate & Hancock
A seasoned strategic communications and public affairs advisor, Isaac Squyres brings to his clients more than 20 years of experience guiding senior executives and organizations through high-stakes challenges, periods of dynamic change and significant moments of opportunity.

Squyres began serving healthcare providers during the challenging M&A environment of the mid- and late-1990s. Since then he's worked with hospitals and health systems of virtually every size to achieve some of their most important objectives, including the formation of Idaho's first health system (St. Luke's Health System), and the largest provider system in South Carolina.

His experience also includes lead campaign advisor roles for a state hospital association on a successful ballot measure initiative and a winning congressional campaign, for which he subsequently guided the transition to office as chief of staff to the congressman.

He founded and managed Squyres Strategic Communications before joining Jarrard Inc. Prior to that, he was a partner at Davies, Moore and Gallatin Public Affairs in Boise, Idaho where he worked with clients to improve their internal infrastructures and grow their business. He began his career at McNeely Pigott & Fox Public Relations in Nashville.

Alex Voss
Associate, Juniper Advisory
Alex is an associate with Juniper. He provides analytical support for Juniper's healthcare clients. He focuses on quantitative analysis, valuations and other research. Prior to Juniper, Alex worked in Asset Management at Ariel Investments where he conducted equity research. He also worked for The Cincinnati Insurance Companies providing underwriters with damage scenario valuations.

Alex holds a BA in Public Policy with a specialization in Finance and Economics from the University of Chicago.

Barton C. Walker
Partner, McGuire Woods
Bart concentrates on mergers, acquisitions, and healthcare regulatory compliance. His practice includes advising healthcare providers as well as equity sponsors and lenders to the healthcare industry. In connection with representing healthcare providers, he works with hospitals, ambulatory surgery centers, dental services organizations (DSOs), urgent care providers, large physician group practices, end-stage renal disease facilities, and home health and DME companies on various regulatory and transactional matters.

He has represented lenders, borrowers and equity sponsors in various healthcare-related financing and acquisition transactions, including asset-based lending, mezzanine and senior credit facilities, and leveraged finance. He has assisted in the re-syndication and start-up of numerous ambulatory surgery centers and hospital-physician joint ventures. He regularly lectures and writes on transactional and regulatory issues affecting a wide range of healthcare businesses.

While earning his law degree from the University of Notre Dame, Bart was named a White Scholar of the Thomas J. White Center on Law and Government. As an undergraduate, he was named a Morehead Scholar at the University of North Carolina at Chapel Hill.

Lanta Wang
Assistant General Counsel, Duke University
Lanta Wang joined the Duke University Office of Counsel in 2019, where she advises Duke University Health System on issues involving general healthcare transactional and regulatory matters, corporate acquisitions, joint ventures and affiliations, physician employment contracts and corporate governance.

Prior to joining Duke, Ms. Wang practiced law at Waller Lansden Dortch & Davis, LLP in Nashville, TN, where she advised health systems, hospital management companies, technology companies and other for-profit and tax-exempt organizations on strategic mergers, acquisitions, divestitures, and other complex business transactions.

Ms. Wang received her Bachelor of Philosophy from Miami University, and her Juris Doctor and Master of Laws degrees from Duke University School of Law. Ms. Wang is a member of the Bar in Illinois, Oregon and Tennessee. Before becoming a lawyer, she was a public health researcher.

Kristian Werling
Partner, McDermott, Will & Emery
Kristian (Krist) Werling represents medical device and biopharmaceutical manufacturers and health care service providers in a wide variety of transactional matters. He also represents private equity and venture capital investors in investments in the life sciences and health care industries. In this capacity, he works with cross-disciplinary teams to conduct legal due diligence and execute acquisitions, add-on acquisitions and divestitures, as well as provide ongoing legal services to portfolio companies. In the health care services arena, Krist has particular experience with transactions and joint ventures involving ambulatory surgical centers, specialty hospitals, dermatology, pain management and anesthesia physician practices and dental practice management companies.

Krist regularly counsels life sciences clients in transactional and regulatory issues, particularly in negotiating agreements in relation to licensing and partnership, clinical research (including clinical trial and contract research organization (CRO)), contract manufacturing and distribution. He has also assisted various medical device and pharmaceutical manufacturers with the implementation of compliance plans and related policies and has been looked to by leading academic medical centers seeking to develop and monetize intellectual property assets.

Previously, Krist served as in-house counsel to Hospira, Inc., a specialty pharmaceutical and medical device manufacturer in Lake Forest, Illinois. Krist is active in the legal and charitable community, where he serves on the board of directors of The Friendship Center, and Swedish Covenant Hospital, an independent, non-profit teaching hospital located on the northwest side of Chicago. Additionally, Krist serves as the chair of the Life Sciences Practice Group of the American Health Lawyers Association.

Editors

Jordan Shields
Managing Director, Juniper Advisory
Jordan has been with Juniper since 2011 and has over 20 years of experience advising hospitals on strategic and financial issues. Prior to Juniper, Jordan was a member of the health system advisory groups at Navigant and Ernst & Young. Jordan holds an MBA from the Kellogg School of Management, where he was named Top Student in Health Industry Management by the faculty. He earned his BA with Honors in Economics from Bowdoin College.

Rex Burgdorfer
Managing Director, Juniper Advisory
Rex has over 15 years of investment banking and strategic financial advisory services experience. He has advised all forms of non-profit hospital systems on merger and acquisition transactions, including community 501(c)3's, religious-sponsored, and local government hospital clients. Rex was previously with Morgan Stanley and holds an MBA from the Kellogg School of Management at Northwestern University.