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the urge to merge

To merge or continue to go it alone: That is the critical decision that many independent hospitals must make in the face of current economic challenges and looming future challenges posed by healthcare reform.

Leaders of independent hospitals and smaller health systems across the nation are increasingly finding themselves at a crossroad. The impact of economic challenges on bottom lines and the march toward full implementation of healthcare reform are prompting hospitals to position themselves for a future that will require greater clinical integration, physician alignment and engagement, production efficiencies, and readiness for population health management.

For many institutions, remaining independent may no longer be possible. Considering a merger, partnership, or affiliation may be the only option to access scale and remain viable.

Many independent hospitals must now decide whether to pursue traditional options for combination (a corporate-member-type merger with a like tax-exempt not-for-profit, or an outright asset sale to a for-profit operator) or to evaluate new models being offered by for-profit operators, private-equity firms, and health insurers. No matter what direction an independent hospital takes, consideration of a strategic partnership or business combination transaction is likely to be the most important decision that it will face.

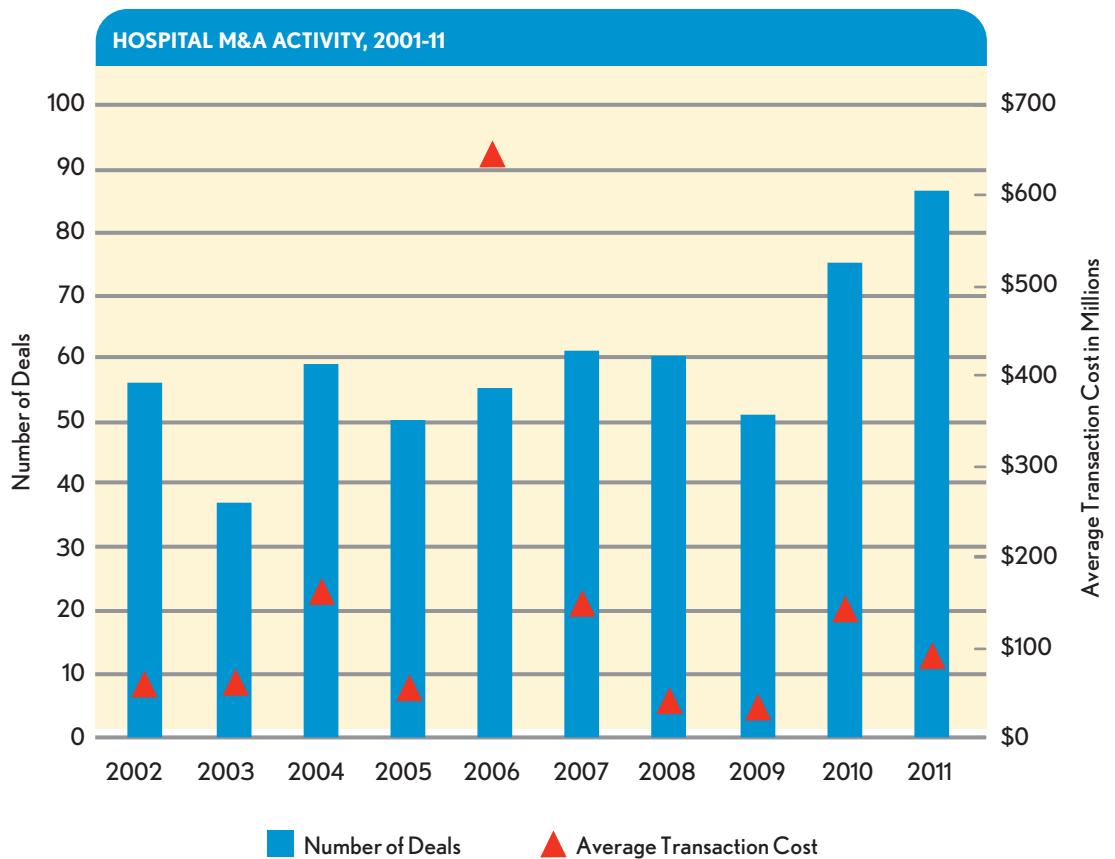
Review of Hospital M&A Activity

Before the passage of the Affordable Care Act (ACA), the number of hospital transactions was nearing historical lows, with only 52 deals occurring in 2009, according to a report from Irving Levin Associates, Inc. With the signing of the healthcare reform bill in March of 2010, the number of hospital transactions increased to 75 in 2010, with a further up-tick to 86 in 2011.^a

AT A GLANCE

- > For many stand-alone hospitals, a merger, partnership, or affiliation may be the only option to access scale and remain viable in the nation's emerging new healthcare delivery system.
- > These organizations can consider many options for affiliation, including traditional options such as affiliation with regional academic medical centers, a merger or takeover to become the corporate member of a large system, and acquisition by a for-profit system.
- > Emerging options include mergers for scale and access to capital, private-equity transactions, and arrangements involving insurance vertical integration.

a. To access Irving Levin & Associates reports for 2009, 2010, and 2011, see the press releases issued in January of 2010, 2011, and 2012, respectively, at www.levinassociates.com/press-release.



Source: DGA Partners analysis of data from *The Hospital M&A Market: Five-Year Review and Outlook*, third edition, Irving Levin Associates, 2012.

Of course, healthcare reform is not the only impetus for providers to seek affiliation. Transaction services data issued by Standard & Poor's indicate that bond downgrades for hospitals significantly outpaced bond upgrades from 2007 to 2009. Although there has been recent stabilization, there also is no doubt that many organizations are still feeling pressure from the economic downturn.

This trend can be attributed to many factors, including payment rates that have not increased as quickly as costs, an unfavorable change in payer mix, and increased capital requirements for investment in technology, infrastructure, and strategic development.

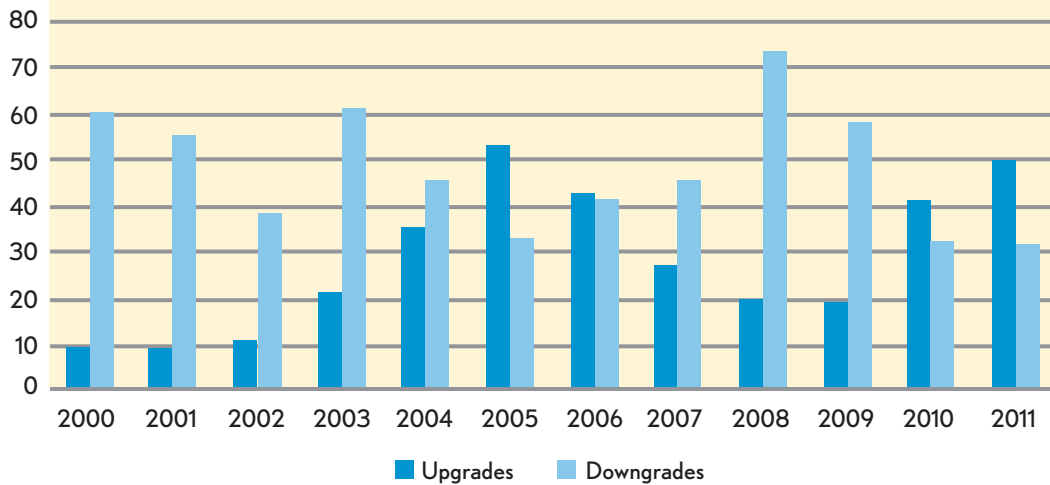
Hospitals with the highest bond ratings are those with the highest net revenues and number of admissions. The drop in scale from Aa to A is dramatic.

Arguably, hospitals with lower ratings are more likely to pursue transactions to gain scale and access to capital. Based on an analysis of ratings from Standard & Poor's, as shown in the exhibit at the top of page 4, about half of all stand-alone hospitals have bond ratings of B or lower. These ratings will pose a problem as the need for capital is exacerbated by the market environment.

Many hospital administrators also are considering whether their hospitals are of sufficient size to be able to respond to the new payment innovation models counted among specific healthcare reform initiatives. Results of a recent survey by the American Hospital Association indicate a common perception that these models will be major factors in future market development (see the exhibit at the bottom of page 4).

Independent hospital boards and executive managers are responding to the ACA with the following questions:

BOND RATING UPGRADES AND DOWNGRADES, 2002-11



Source: Arrick, M.D., and Sweeney, L., *The U.S. Not-for-Profit Health Care Sector's Rating Stability Is Vulnerable to Headwinds After 2012*, Standard & Poor's, Jan. 25, 2012.

- > Are we ready for anticipated payment innovations?
- > Are we capable of engaging the necessary provider partners to succeed in these arrangements?
- > Does our hospital need to gain access to size and critical mass to be capable of assuming risk?
- > Does our hospital have the size to collaborate with health plans to offer narrow network products on a health insurance exchange?
- > How might expected changes in the insurance market affect the types of patients at our hospital, and what are the implications for our competition and other mergers and consolidation in the market?

quaternary programs, while community hospitals on the fringe of these AMC's service areas have looked to clinical affiliation to provide their communities with more integrated and seamless access to highly specialized services. This "spoke and wheel" strategy allows independent hospitals to coordinate these services for their patients without sacrificing significant autonomy and independence. Common affiliations include telemedicine programs, specialty cancer care, stroke, highly specialized surgery, trauma, and neonatology.

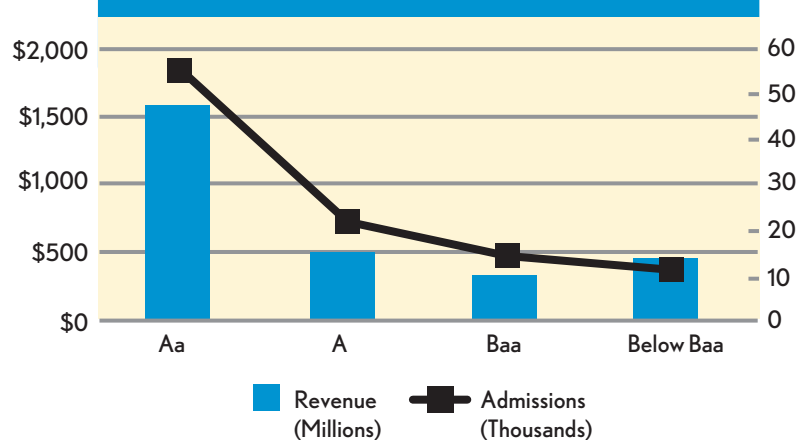
These and other considerations are relevant in a hospital's self-evaluation of its capacity to remain independent.

Traditional Affiliation Options

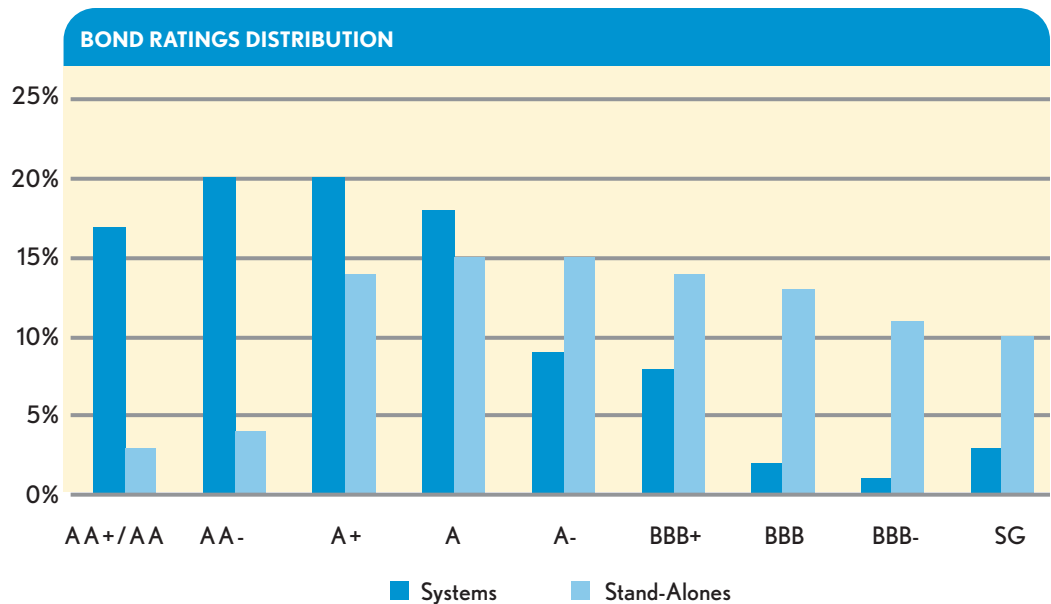
Hospitals have been affiliating, merging, and forming systems in significant numbers since the mid-1980s. With more than 25 years of lessons learned, consolidation is a mature and well-established strategy.

Clinical affiliations. Regional academic medical centers (AMCs) have sought strategic affiliations as a way to build referrals for their tertiary and

REVENUE AND ADMISSIONS BY RATING CATEGORY



Source: Moody's Investor's Service Not-for-Profit Hospital Medians, Aug. 2, 2011.



Source: DGA Partners analysis of citations provided by Standard & Poor's as of June 30, 2011.

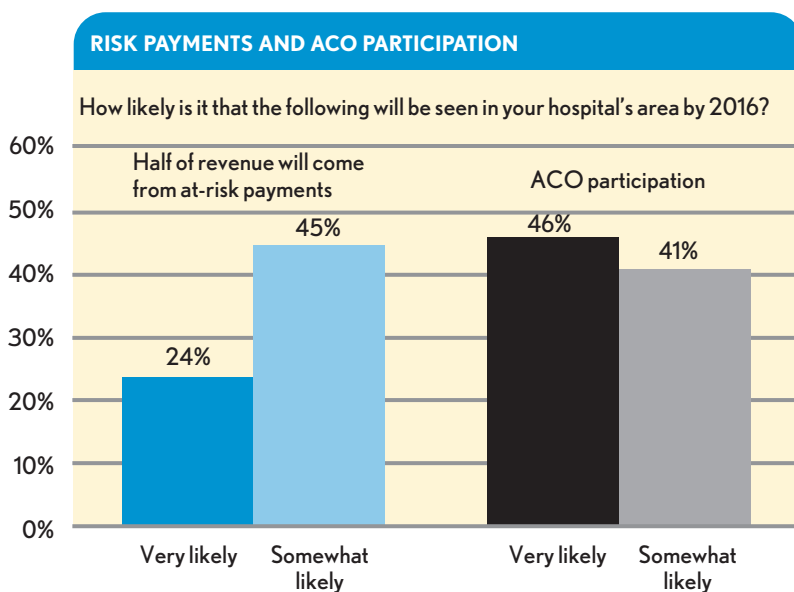
These clinical affiliations have generated variable results. AMCs and community hospitals continue to pursue them because they preserve the participant's independence to a degree, and they avoid raising much more challenging issues associated with governance, capital access, and other concerns required in closer business combinations. For community hospitals, relationships of this sort can represent an "engagement before marriage"

strategy with significant interim benefit. This strategy is a favorable one for community hospitals that are financially stable and risk-averse.

Mergers and takeovers. In the tax-exempt, not-for-profit sector, hospitals have often used the corporate member merger or takeover model. Under this approach, typically the larger hospital or system assumes responsibility for the smaller hospital's balance sheet and becomes its corporate member. The system then has the authority to appoint the board for the previously independent hospital, as well as certain key reserved powers. Financial commitments are often made, leading to strategic and operational integration.

This option has the greatest appeal to boards that remain committed to retaining not-for-profit status for philosophical reasons and that wish to keep an active hand in the governance of the institution.

The not-for-profit sector also has employed joint operating agreements, in which effectively only the profit and loss statement is merged while balance sheets remain separate. The degree of separateness inherent in this structure, however, makes governance, strategy, and capital finances



Source: *Futurescan 2011: Healthcare Trends and Implications 2011-2016*, Health Administration Press, Jan. 5, 2011.

difficult to coordinate, manage, and prioritize, which has led to mixed results with this model.

Buying and selling. The traditional investor-owned, for-profit sector has existed for years, sometimes thriving, and is characterized by ever-evolving corporate players, takeovers, and divestitures. Hospitals are often bought and sold among for-profit systems, with a handful of seasoned executives and investment bankers driving the deals.

In recent years, many tax-exempt hospitals have opted to sell their organizations to these successful operators, with the boards turning over any proceeds to foundations. These foundations continue to further the mission of the legacy hospital by providing financial support to various community-based and other public health initiatives. This option is most suitable when a hospital's leadership has concluded that the organization and the community will be best served by turning the hospital over to an owner/operator with a strong track record, and that the board and community will be better off using sale proceeds to support other community health improvement initiatives.

Emerging Options

In the past couple of years, new players and transactions have been redefining the landscape of affiliation and consolidation. Even hospitals and health systems that are in a reasonable financial position may consider affiliation with a larger hospital or system in the community, solely to position themselves for strategic or financial success.

Some recent transactions are breaking new ground and illustrate deal structure innovations, providing access to new sources of capital.

Mergers for scale and access to capital. In the spring of 2011, Ascension Health, a large, not-for-profit Catholic health system headquartered in St. Louis, purchased Chicago's three-hospital Alexian Brothers Health System. In many ways, the deal was largely about scale, rather than gaining additional presence in the local or regional

market. Though Alexian was profitable, it sought a partner that could help retire debt and provide capital for facility improvements. As a large national organization, Ascension could serve in that role.

To purchase Alexian Brothers, Ascension formally established a joint venture with the private-equity firm Oak Hill Capital Partners to form Ascension Health Care Network (AHCN). This step allowed the organization to move beyond its position in the tax-exempt bond market to obtain capital to fund new acquisitions and pursue strategically important opportunities (Solomont, E. B., "Ascension, Alexian Brothers Ink Deal for Hospitals, Senior Care Facilities," *St. Louis Business Journal*, Sept. 14, 2011).

Private-equity transactions. In October 2010, following other highly successful private-equity-backed transactions by for-profit systems, including the Hospital Corporation of America (HCA), Steward Health Care—a for-profit hospital chain funded by the private-equity firm Cerberus Capital—acquired the six hospitals of the not-for-profit Catholic health system Caritas Christi Health Care. Since then, the system has added four other hospitals in Eastern Massachusetts and appears committed to pursuing other opportunities (Mohl, B., "Cerberus's Health Care Play," *CommonWealth*, July 10, 2012).

Steward's acquisitions had been historically underperforming community hospitals. Cerberus Capital sees an opportunity in their purchase, and Steward has employed a strategy focusing on providing efficient and low-cost care in a state where providers are rewarded for efficient operations.

Steward recognized that more than 50 percent of routine inpatient care was occurring at teaching and specialty hospitals, where costs are high. By keeping care in local hospitals, Steward pursues a dual-pronged approach: It enhances hospital revenues and receives rewards from Massachusetts for population health savings. Steward even offers

its own health insurance plan, priced 20 to 30 percent below market. This plan features a limited, narrow network, in which treatment is covered only at its own hospitals, with some exceptions for medically necessary care. This type of model could appeal to other hospitals as a means to position themselves for success when the nation looks much more like Massachusetts, with insurance exchanges and greater access.

Cerberus is not the only private-equity firm that has identified opportunity in the hospital industry. In January 2011, Nashville, Tenn.-based Vanguard Health, owned by the private-equity firm Blackstone Group, acquired Detroit Medical Center (DMC) and its eight hospitals. As part of the transaction, Vanguard agreed to infuse \$850 million over five years to fund capital projects for the DMC hospitals. Like Alexian Brothers, DMC was a profitable entity hoping to access capital for infrastructure improvements. Vanguard and Blackstone are betting big on having a larger presence in the market and believe that the investment positions their organizations to compete more effectively.

To some extent, the jury remains out on the role of private equity in mergers and acquisitions. HCA has recently taken heat for pursuing controversial incentives to satisfy its private-equity backers. The hospital system faces accusations that it bills more aggressively than it should, has found ways to reduce cost at the expense of patients, and too frequently refuses patients care in its emergency department (Creswell, J., and Abelson, R., "A Giant Hospital Chain Is Blazing a Profit Trail," *The New York Times*, Aug. 14, 2012).

Insurance vertical integration. An insurer partnership may be a strategy for organizations in competitive markets and for hospitals looking to focus more broadly on population health. Although there are admittedly many catalysts behind the autumn 2011 announcement of Highmark's purchase of West Penn Allegheny Health System (WPAHS) in Western Pennsylvania, the stated objective was to form an integrated delivery system (IDS) to marry the finances and delivery of

care. At the time, there was national significance to this merger, given its proposed objective to improve quality and lower the cost of care in the region. More recently, the transaction has dissolved for a variety of reasons, exemplifying the complexity of relationships between payers and providers.

Many insurers in other markets may pursue comparable strategies to compete in the new environment. Hospitals and health systems, however, may choose to work with insurers in a different way, stopping short of developing IDSs. These arrangements are increasing in popularity. They feature shared savings arrangements, patient population management, and innovative agreements to stem the rising cost of care.

One example is the arrangement between Kaleida Health of Buffalo and HealthNow (Blue Cross Blue Shield of Western New York), which recently announced plans to develop a physician-led network to improve care coordination, reduce duplication, and increase quality. There is no doubt that partnerships of this variety are likely to increase as trust and experience evolves over time.

More Uncertainty and Less Confidence than Ever

Despite the apparent frenzied pace of transaction and consolidation activity, it also appears that these transactions face increasing difficulty in coming to successful fruition. Many organizations that started moving toward consolidation at light speed are stepping back as they recognize the need to evaluate alternatives or discover transaction barriers during due diligence.

Historically, the incidence of dissolved mergers—those in which a letter of intent is signed and publicly disclosed, but the transaction does not close—did not exceed 5 percent. Last year, however, according to one source, 25 to 50 percent of letters of intent failed (Brown, T.C., et al., "Current Trends in Hospital Mergers and Acquisitions," *hfm*, March 2012). Although this high percentage of failed transactions might slow

the pace of consolidation, it has done nothing to slow the growing interest in new business partnerships.

Required Attributes for Independence






In these fast-changing and challenging times, independent stand-alone hospitals should systematically and routinely evaluate their ability to remain independent. Management and the boards of these hospitals should conduct reviews of key business indicators at least twice a year.

Hospital management should establish minimally acceptable targets, when possible, for each of the key metrics (e.g., admissions, market share, and operating margin) so the board can determine

whether problem areas are emerging. For more qualitative areas, progress should be measured against the organization's strategic plan and key strategic imperatives and goals.

In short, to ascertain whether their organizations have the overall strength and viability to remain independent, leaders of stand-alone hospitals should consider the extent to which their organizations display five major organizational attributes:

- > Strong market position
- > Excellent financial performance and access to capital
- > Effective physician-hospital alignment
- > Readiness for population health management
- > Capable and engaged leadership

INDEPENDENCE DASHBOARD		
Organizational Attribute	Assessment	Key Indicators
Market Position		<ul style="list-style-type: none"> > Market share overall and by major product line > Admissions trends by service and product line > Emergency department and outpatient volume trends > Key competitor activity > Outmigration trends > Population and housing trends
Financial Performance and Access to Capital		<ul style="list-style-type: none"> > Profitability—operating and bottom line > Cash position > Leverage and overall capitalization
Physician-Hospital Alignment		<ul style="list-style-type: none"> > Medical staff resources by specialty (additions, retirements, etc.) > Relationship between hospital and medical staff > Consolidation and acquisition activity
Population Health Management Readiness		<ul style="list-style-type: none"> > Overall preparedness for clinical integration and population health management > Positioning to manage new payment innovations (ACOs, bundled payments, etc.) > Degree of adoption of care management and clinical IT
Leadership		<ul style="list-style-type: none"> > Effectiveness/historical performance of current management team > Strength of relationship between board of trustees and administration > Presence of medical leadership and structure necessary for success



Weak



Moderate



Strong



In this sample partner scorecard, four prospective health system partners are evaluated according to nine criteria on a scale of 1 (weakest) to 5 (strongest).

POTENTIAL AFFILIATION PARTNER SCORECARD				
Criteria for Evaluating Partners	Health System 1	Health System 2	Health System 3	Health System 4
Culture Style of engagement	3	4	3	2
Experience Track record in acquiring and integrating community hospitals	4	3	3	2
Autonomy	3	4	3	?
Financial Ability/desire to provide capital and payer contracting	3	4	2	1
Operations Support/integration of back office & IT	3	4	4	2
Clinical Support seamless, accessible continuum of care	3	4	4	2
Medical Staff Support development and recruitment	5	5	3	3
Level of Interest	4	5	2	2
Barriers	2	5	2	1

Examination of key areas and comparison of actual performance with targets and goals should be followed by overall assessments of each organizational attribute. If any of these areas are weak or are becoming weaker, then it may be time to begin considering affiliation options. Independent hospitals, and even smaller health systems, will need to have favorable assessments in all these areas to be viable in an increasingly challenging environment.

The Decision to Affiliate

If ongoing updates and reviews of a hospital's "independence dashboard" lead to an inevitable conclusion that the hospital needs a partner, the next, imperative task is to clearly identify, articulate, and prioritize the organization's needs and goals for an affiliation. This process should follow quite logically from the dashboard, and requires comprehensive, organized, and systematic input from the entire board and senior management.

For example, key goals for affiliation might include:

- > Preserving and expanding existing clinical services

- > Achieving market-leading quality, service, and efficiency
- > Ensuring a seamless, integrated, and patient-focused experience
- > Providing financial stability
- > Supporting further development and recruitment of medical staff
- > Adding value to all parties
- > Preserving a degree of local governance/control

Because the question of independence is one of the most important fiduciary duties of a board, it is important to be inclusive in the process of partner selection, evaluation, and decision making. A small minority should never get out in front of the organization's overall leadership on a partnering initiative.

Leadership should also identify any non-negotiables at this time, to avoid future roadblocks in the affiliation process. For example, non-negotiable conditions might include:

- > The hospital's ability to continue to maintain a full-service obstetrics or emergency department

- > The assurance that the former independent can continue to comply with ethical and religious directives for Catholic healthcare services
- > The partner's commitment to at least \$50 million in capital investment over the next three years

The Quest for a Partner

Once goals have been prioritized and non-negotiables are in hand, an independent hospital is in a position to begin identifying potential partners—whether for traditional models of partnership or emerging ones. The independent can initiate discussions with the organizations it believes are likely to be the preferred partners, or it can open up the process and solicit expressions of interest from the range of potential not-for-profit, for-profit, and private-equity type partners.

The hospital board should be involved in deciding on the approach and process that is right for the

organization. Potential partners can be evaluated based on the nine criteria presented in the exhibit on page 8, and a partner scorecard can be developed, which should aid the board and senior management in homing in on the best choice. ●

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