



Critical Issues in Hospital and Health System M&A

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Executive Summary

Since the enactment of the Affordable Care Act, the pace of hospital and health system consolidation has accelerated to a level not seen since the late 1990s, when hospitals were reacting to the formation of HMOs. The year 2013 saw a total of 87 consolidation transactions, following 105 in 2012. This volume represents a significant increase over 58, the median number of transactions completed each year between 2001 and 2011. Unlike the last wave of consolidation, which was driven primarily by financial and reimbursement considerations, today's hospital mergers are just as likely to be between financially strong partners as they are to be in response to challenged operations or economics. Hospital companies increasingly are turning to mergers and acquisitions as a tool to improve quality, manage risk, access capital and contend with the changing regulatory environment. The articles in this collection explore the drivers of the current wave of consolidation, address the causes of transaction failures and review the range of structural alternatives available in the marketplace.

Preparing a Hospital or Health System for Sale or Partnership Transactions

Currently, horizontal consolidation (hospital-to-hospital combinations) is 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 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 ensuring that a hospital transaction can be successfully completed is advance preparation, which mitigates two significant 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 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 creating a positive outcome for all stakeholders.

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 for-profit hospital management company acquires a nonprofit health system, tax-exempt bonds usually are fully discharged out of the transaction proceeds, making the bond covenants less relevant. However, in transactions between

nonprofit 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.

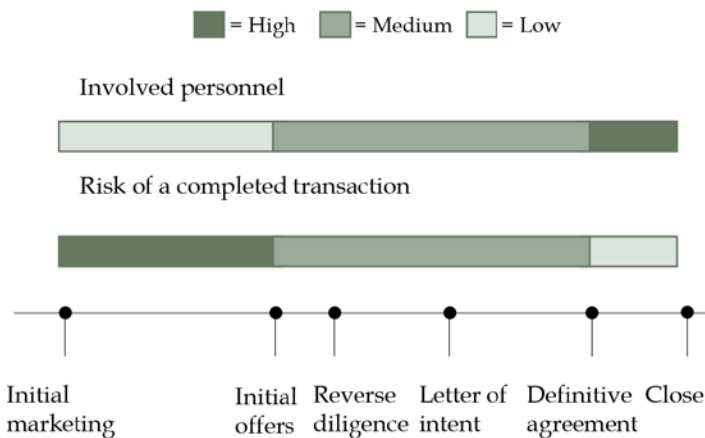
Nonprofit health systems that are acquirers also can face bond covenant issues. In many cases, bond indentures require the maintenance of certain financial ratios that can be violated if the balance sheet of the acquired hospital is consolidated. Bond covenants also often restrict health systems from assuming additional debt (such as the bond debt of the acquired hospital). In cashless member substitution transactions between nonprofit 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 acquirer should ensure that its own bond covenants do not place restrictions on the amount of capital that can be spent on projects outside of the acquirer's bond obligated group.

Regardless of the transaction's structure type, 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 for the need to refinance.

PENSION PLAN DEFICITS

Underfunded pension plans present an issue when negotiating change-of-control transactions. Approximately 72 percent of the 460 not-for-profit hospitals that are rated by Moody's Investors Service offer defined benefit plans to their employees (referred to herein as “pension plans”). According to Standard & Poor's, the median funded status of defined benefit plans for hospitals was 69.4 percent in 2012, down from 72.6 percent in 2011. If a pension plan is significantly

underfunded—*i.e.*, the benefit obligations under the pension plan exceed the assets held in trust to settle the accrued benefits—the pension plan represents a concern from both a liability and a 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 likely will exclude the underfunded pension plan from the transaction so that the buyer is not legally obligated to maintain or fund the pension plan following the closing.



Tactics: risk exchange

The seller may be required either to maintain the underfunded pension plan or 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 affect the preferred structure of a transaction and the operations of the acquired hospital post-closing.

PHYSICIAN REFERRAL SOURCE RELATIONSHIPS

Large nonprofit systems and for-profit consolidators alike heavily scrutinize physician referral source relationships

because the financial impact of non-compliance 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 False Claims Act violations 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-kickback 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. Non-compliant relationships should be identified, corrected and, if necessary, self-disclosed to the appropriate regulator.

ERRORS AND OMISSIONS (MALPRACTICE) COVERAGE AND TAIL INSURANCE

Most buyers of hospitals 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 malpractice insurance (also known as "errors and omissions coverage") in the state in which the hospital operates. If the hospital's malpractice coverage was expensive, the tail insurance policy likely will be costly also. If a hospital that is being acquired maintains its own captive malpractice insurance or is "self-insured," that 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.

LICENSES, PERMITS AND ACCREDITATIONS

Two key issues with respect to licenses, permits and accreditations should be examined before a transaction. First, all 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 in order to enable a potential acquirer 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 affect any of its licenses or permits. Certificate of Need approvals or exemptions, state department of health notices, U.S. Drug Enforcement Administration notices, Federal Communications Commission licenses, and Joint Commission or other accrediting body issues should be understood so that acquirers and the hospital's leadership can accurately convey the timeline to stakeholders.

PROGRAM INTEGRITY CONTRACTOR AUDITS

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 acquirers, because it affects 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 having an outside professional or consultant conduct a re-audit in order to demonstrate compliance. Even if

exposure seems minor, buyers often view any governmental billing and coding issues as significant.

COMMERCIAL INSURANCE RELATIONSHIPS

Commercial insurers (*i.e.*, Blue Cross Blue Shield, United Healthcare) still pay for the majority of health care 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 in order to mitigate 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 making a preemptive change, rather than waiting for the acquirer to later reduce its financial commitment when it discovers that the hospital's revenues are inflated as a result of non-compliance with an insurer's policies.

COMPLIANCE PROGRAM

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

- 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 health care compliance and privacy training completed for employees and physicians?
- Do hospital board minutes reflect senior management's attention to health care compliance issues?
- Involving the hospital or health system's compliance professionals early is critical to successfully preparing for these inquiries.

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 U.S. 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 as a result of an 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, 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.

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 situation is of particular concern in transactions where nonprofit hospitals are converted to for-profit status. In many cases, deed restrictions can limit the use of land or buildings to charitable or nonprofit uses. These restrictions also can include reversionary interests that 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 affect 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.

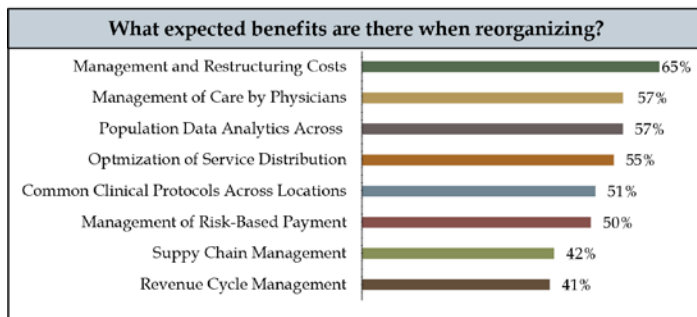
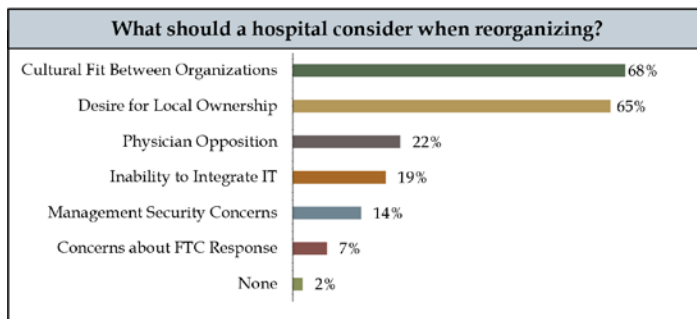
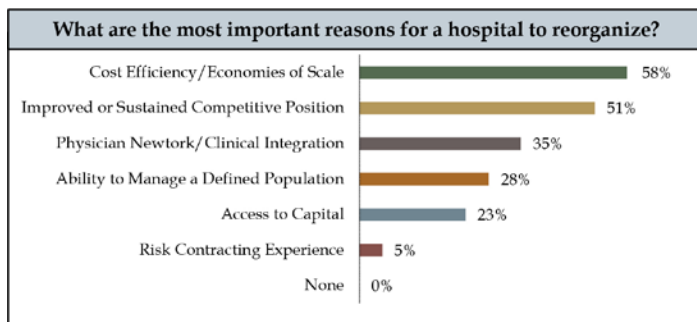
Consequently, a hospital must identify and review all real estate restrictions (including restrictions in lease agreements) to understand their potential impact on transactions. Where there are material restrictions on the use of the hospital's main campus, the hospital may select potential transaction partners based upon their ability to comply with the restrictions, or 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 it selects a partner, it may be unpleasantly surprised when the real estate restrictions come to light during the due diligence process, potentially delaying or derailing the transaction.

KEY TAKEAWAYS

In order to position themselves 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.

Developing a Hospital Transaction Strategy and Process

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.



Benefits of reorganizing

Source: Healthcare Financial Management Association;
Beckers Hospital Review

In an effective transaction process, 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 health care 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 affect 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 non-recurring market-centric issues as well as recurring hospital-centric issues. Market-centric issues include the structure of the health care 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 also should consider activity within the regional market and assess how that activity will affect 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, boards, 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 (FTC) 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 review includes all of the alternatives available that do not include a transaction, such as a contractual or branding affiliation with a larger system, divesting non-core assets, entering into a joint operating agreement or participating in an accountable care organization. The range also includes alternatives such as 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 such as 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 nonprofit system or an outright sale, typically to an investor-owned company or a buyer joint venture.

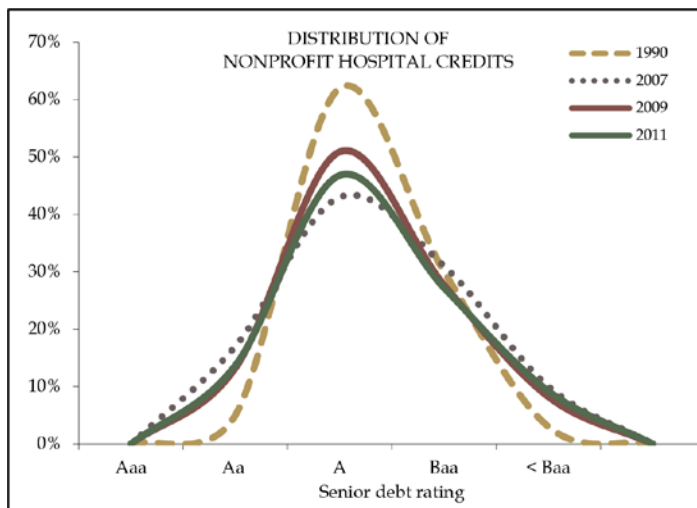
It is important for the board to keep an open mind throughout the options assessment. This process is designed to be exploratory and to uncover the full range of available alternatives. A common mistake of organizations that carefully develop their objectives but do not pursue a structured options assessment is to bounce from one narrow tactic to the next. Instead of stepping back and evaluating their situation within the broad context of the market, they 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 Process

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.



Source: Moody's, Juniper estimates

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 assures the board that it has selected the option that best meets its objectives.

KEY TAKEAWAYS

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 non-economic 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.

The Role of the Nonprofit Hospital Board in Consolidation Transactions

The vast majority of hospital consolidation transactions involve a nonprofit health system. In such cases, ultimately it is the nonprofit board's decision whether, and under what terms and conditions, a hospital pursues a consolidation transaction. It is critical for a nonprofit 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:

- Be informed about the fiduciary obligations incumbent on the directors
- Establish good governance processes in advance
- 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 the 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 nonprofit 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, nonprofit directors are bound to serve the best interests of the organization itself, and not another constituency.

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.

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.

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.

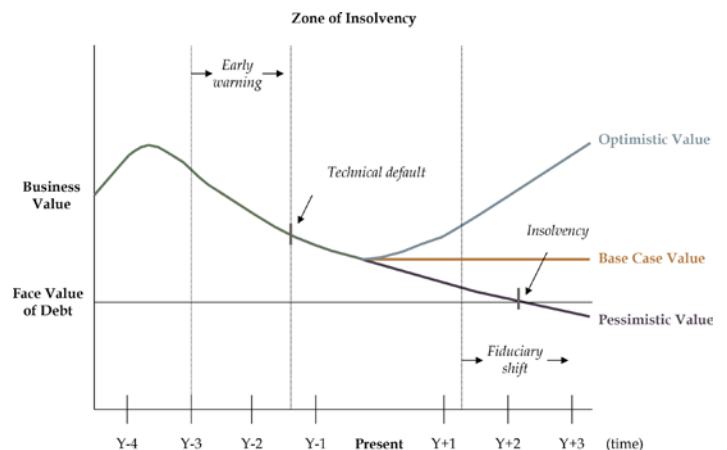
ADVANCE ESTABLISHMENT OF GOOD GOVERNANCE STRUCTURES

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. For more information, see “The Board’s ‘M&A’ Fiduciary Duty Checklist” and “The Board’s Role in the M&A Process: Meeting Fiduciary Obligations,” published by the Governance Institute.

KEY ISSUES FOR BOARD CONSIDERATION

As the overseer and steward of the nonprofit 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, these issues will include the following:

- *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.
- *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.
- *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.

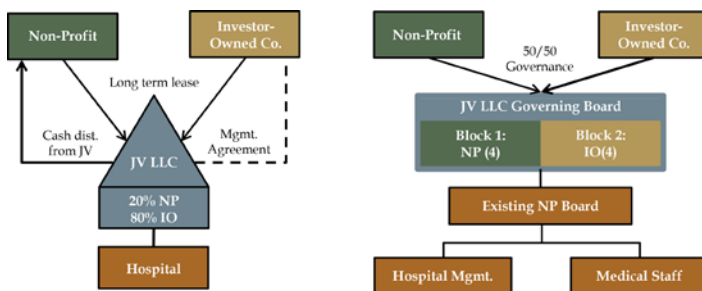
- *Be prepared to handle federal antitrust matters.* Depending on the size and structure of the proposed consolidation transaction, the parties may be required to file a Hart-Scott-Rodino (HSR) application with the Federal Trade Commission (FTC) and the U.S. Department of Justice (DOJ). The HSR application 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 pro-competitive 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 above.

KEY TAKEAWAYS

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.

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

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 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 similar to managed care—airline; auto; and food, beverage and tobacco, for example—the 50 largest companies hold market shares in excess of 75 percent. The 50 largest hospital companies together command less than 25 percent market share. The hospital industry has no “large” companies, and no companies have full access to capital like major manufacturing companies have—e.g., commercial paper markets, equity markets, debt markets, synthetic markets, foreign listings.

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.

Significant innovation has occurred in the variety of structures—including “hybrid” structures—that hospitals and health care systems are using to work together. These structures include the following:

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

DESCRIPTIONS

Seller joint ventures are typically formed between a community hospital and an investor-owned company. 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 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.

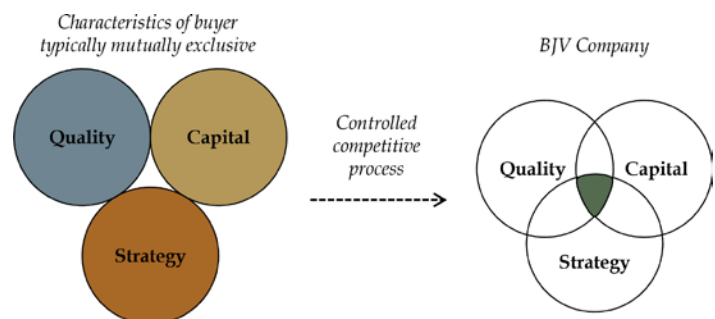
Buyer joint ventures combine the respective expertise of a clinical partner and an equity-sponsored system. The clinical partner holds a minority of the equity interest (typically 3 percent to 20 percent) and is responsible for overseeing medical safety and quality. The investor-owned partner provides 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.

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 nonprofit 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.

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 Sentara in Virginia. Consolidation transactions are

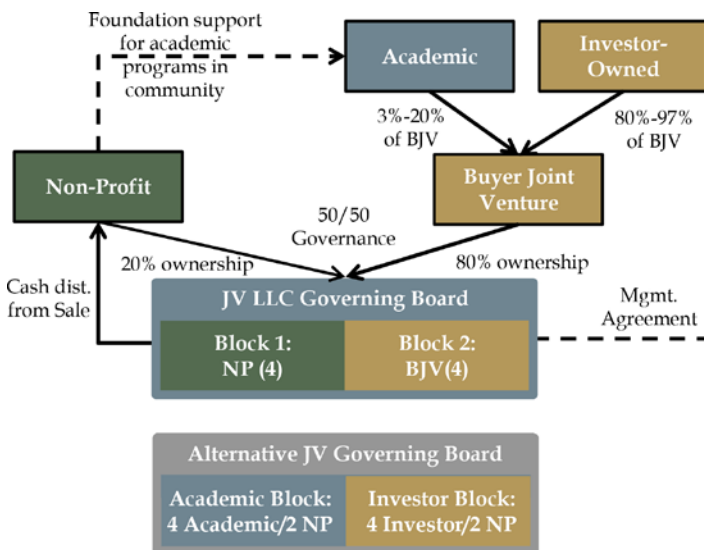
difficult to execute. To work, they require two health systems that share a common vision and are similarly sized. It is not unusual for consolidation transaction discussions to unravel over near-term concerns like the identity of the new company’s board chair or chief executive officer. Although tricky to complete, when implemented, consolidation transactions have proven to be the genesis of very successful hospital systems.

Membership substitutions are the most common structures between merging nonprofit hospital systems. This structure is analogous to a stock sale transaction in corporate finance. The seller transfers its ownership to the nonprofit acquirer 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 nonprofit 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 nonprofit acquirer 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 nonprofit sellers and investor-owned acquirers. These are also seen between two nonprofit partners, when the acquiring nonprofit 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.



KEY TAKEAWAYS

Maximizing the outcomes of each of these strategic options requires board members to understand generally 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. Boards equipped with knowledge of these innovative structures will be better able to contend with an increasingly complex operating environment.

Conclusion

Change-of-control transactions are significant events that present risk and opportunities for communities as well as hospital directors, management, physicians and staff. Organizations that effectively focus on the underlying opportunities of the transaction and their situation can achieve maximum value for their communities. This collection of articles provides a framework for hospital boards and management teams to position their organizations for successful transactions. The importance of preparation and strategy in the development of an effective process cannot be understated. Hospital boards must understand their roles and responsibilities, and the range of strategic alternatives presented by today's marketplace.

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