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2016 Health Care Transactions
Resource Guide

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Acknowledging the Possible: When Affiliations Go Bad

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In the airline industry, safety gains have reduced the rate of crashes such that the number of fatal crashes annually has fallen even as air traffic has grown. This success has not, however, been repeated in the world of hospital mergers. For example:

- Approximately half of the parties involved in a hospital merger—namely, those on the "sell" side—are inexperienced in such transactions due to lack of prior merger experience.
- Hospitals may lack the tools they need to effectively handle a merger transaction. In some states, current consolidation deters or precludes the most experienced "buy" side entities from pursuing affiliates for strategic and/or anti-trust reasons.
- The current regulatory, compliance, and operating environment for hospital mergers is becoming increasingly complex and risky for merger participants.

Reducing the Risks of a Merger Misadventure

It is vital to ensure that the hospital and its partner share a compelling and enduring strategic rationale for the merger. A decision to affiliate should only be made after careful evaluation of alternative strategic options and a Board's consensus selection of a preferred affiliation partner, structure, and proposal as the best vehicle for achieving the organization's strategic objectives.

At the outset of exploring strategic options, it is essential to understand that there are no risk-free strategic options for hospitals. Continued independence will subject the organization to ongoing "execution risk" that is likely to grow more acute given payment reductions, the growing prevalence of high deductible health plans, increasing consumerism, value-based purchasing, and the challenges of population health-based payment forced by the industry. The decision to affiliate is often driven by a desire to reduce stand-alone execution risk. However, affiliating introduces "partner risk," which can be mitigated at the outset by:

- Selecting a strategically aligned partner via a competitive process (in most instances);
- Designing a structure customized to the organization's strategic objectives; and
- Negotiating contractually enforceable terms.

Once you have selected your preferred partner, defined the affiliation structure, and negotiated key terms and contractual commitments, it is critical to ensure that the merged entity has effective leadership that inspires buy-in and trust. Rigorous and effective post-affiliation execution should include:

- Focusing on early wins to avoid a zero-sum merger where any party's benefit is balanced exactly by the losses of the other party.
- Tracking key performance indicators to create or strengthen a culture of accountability.
- Ensuring that stakeholders receive thoughtful and proactive communication early and often.
- Proactively studying the cultures of the organizations to identify and address areas that will require particular care and nurturing to avoid dysfunction.

The Consequences of a Bad Marriage

Deciding to walk away before an affiliation is finalized is not a worst case outcome. In fact, a far worse scenario would be to enter into an affiliation that does not create compelling strategic alignment or durably address organizational needs and constraints. It is important to avoid wishful thinking about the risks of a stand-alone strategy or the cost savings of a merger. Because most

mergers fail to generate the cost savings envisioned, the parties should identify other compelling rationales for the affiliation.

The costs and disruption from consummating an ill-conceived merger can be devastating to an organization's finances, reputation, and strategic position. The organization's standing with physicians and future potential partners may be harmed. A leader of an academic medical center that exited a failed merger once commented on the magnitude of the costs by rhetorically asking, "Have you ever seen a divorce that was cheaper than the wedding?"

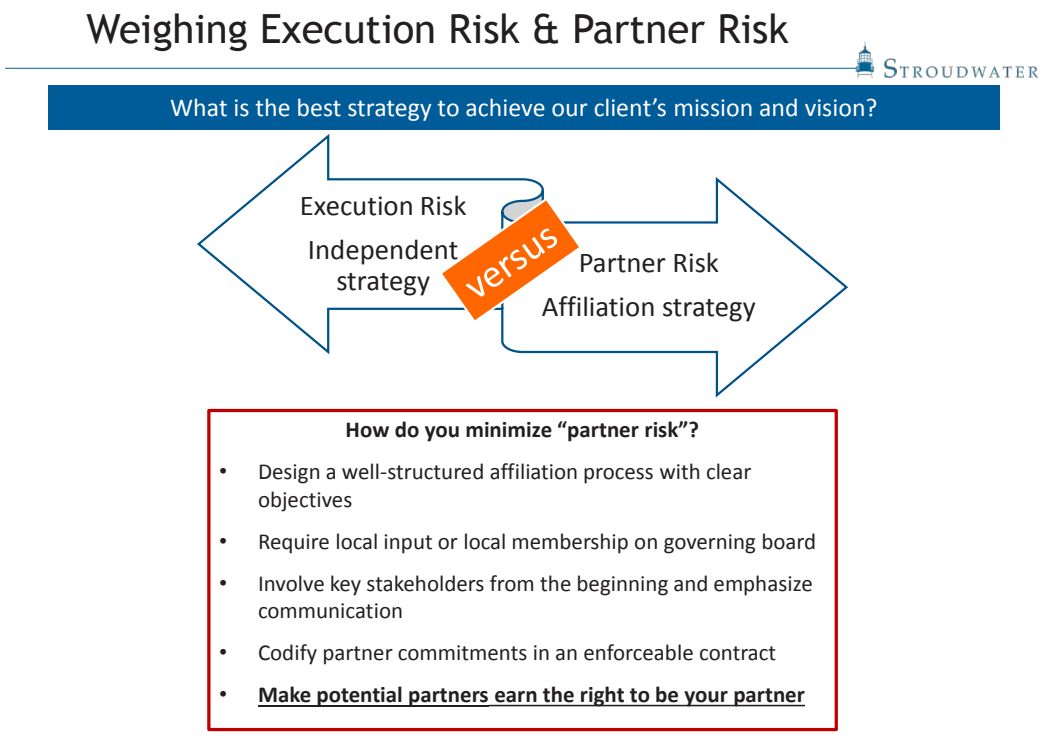
Case Studies: Divorces Done Cheap and Not So Cheap

Regional Medical Center. RMC is a high-performing regional referral center that joined a five-hospital system centered in a mid-size MSA approximately 60 minutes away. Through the affiliation, RMC sought to realize procurement efficiencies; reduce cost of capital via the system-obligated group; provide opportunities for staff education and sharing of best practices; and improve provider recruitment. After five years, the system was requiring RMC to more tightly integrate and surrender key reserve powers held by the RMC Board due to enactment of the Sarbanes-Oxley reforms. RMC staff realized that best practices within the system often originated from RMC. Increasingly, RMC staff was asked to share their successes with other system affiliates, which, while flattering, raised the question of the value the system provided for RMC. RMC had significant debt capacity and a strong stand-alone credit profile. After five years in the system, RMC exercised its (unique) unilateral option to exit the system and refinanced its debt outside of the system-obligated group. Today, RMC remains a high performing, independent organization, while still participating in many system initiatives as an independent affiliate.

Key Factors: Stroudwater advised on RMC's affiliation and dis-affiliation. RMC was a strong, high performing organization for which the five-hospital system failed to provide the sought-after benefits. RMC also had a unilateral, no-cause exit option that was exercised when the rules of engagement with the system were going to change. Most systems will not grant such an unlimited exit provision to an affiliate, preferring to limit the exit option in duration and for specified, limited causes.

Jones Health System. JHS was formed via the creation of a Joint Operating Agreement (JOA) between two proximate community hospitals, Memorial Hospital (MH) and Green Hospital (GH). A large non-profit health system was retained to manage the new health system. As both members had weak balance sheets and anemic cash flows, JHS was undercapitalized from inception. Leadership from MH was elevated to lead JHS. When early wins at both MH and GH proved elusive because of difficult market conditions and the recession, relations between the two members deteriorated. If MH received a significant investment, for example, key stakeholders at GH believed those resources were diverted from their facility. JHS leadership focused on building MH into its own referral hub, but GH physicians saw their true referral partner as the tertiary hub 60 minutes away. The end-of-year true-up required by the JOA compelled the member that experienced less loss to ship funds to the member that lost more as a "due to" on their balance sheet going forward. That arrangement proved toxic to Board functioning, and the two camps dug in.

Key Factors: JHS retained Stroudwater to define a path forward for JHS and its members. Given the distrust engendered and JHS's weak financial condition, it became clear that JHS was unworkable without an affiliate. Dissolving the JOA and allowing MH and GH to go their separate ways was also unworkable, as the costs of dissolving JHS, the weakened financial state of MH



and GH, market conditions, and the need to recreate system infrastructure independently at both MH and GH would sink both members. A new partner was needed to recapitalize MH and GH, separately or together. After conducting an affiliation process that required the blessing of JHS, MH, GH, and the non-profit manager, JHS was dissolved; MH and GH affiliated, separately, with a new partner. The instability of JOAs, the limitations of management arrangements for undercapitalized hospitals, and the need for early wins and leadership that earns buy-in and trust are key takeaways from the JHS saga.

Smith Medical Center. SMC is a community hospital located in a college town approximately 75 minutes from its academic referral partner. Approximately 15 years earlier, SMC folded its entire medical staff into a multi-specialty group (MSG) owned by its academic referral partner and formed a joint operating agreement (JOA) with the MSG. The JOA called for SMC and MSG to (i) eliminate duplicate service offerings for efficiency gains, (ii) collaborate on care coordination to achieve quality and cost objectives, and (iii) share in the revenue and costs of providing these services locally. For 10 years, the JOA worked well, sustaining a stable, high quality medical community with the annual operating performance of SMC and MSG tracking parallel to allow for a non-controversial end-of-year financial true-up as spelled out in the JOA. However, approximately five years ago, changes in reimbursement and utilization trends began to adversely impact SMC. The state passed a hospital tax to help fund its Medicaid program, further eroding SMC's financial performance. After being downgraded several times, SMC and the academic referral parent of MSG replaced the JOA and made the academic referral partner the sole member of SMC.

Key Factors: Stroudwater advised SMC on its strategic options when it was searching for an alternative to replace the JOA. The end-of-year true-up and workings of a JOA made it unstable and vulnerable to changes in the relative performance of its members. Ultimately, SMC found a more durable and sustainable affiliation structure with its academic referral partner but without the benefit of comparing multiple options side-by-side and introducing competition into the selection of a permanent partner. While the JOA was selected initially because it fostered collaboration without much loss of control at SMC, turning over the entire medical staff to another entity ensured de facto loss of control. The termination provisions of the JOA also effectively precluded SMC's ability to compare alternative partnering options.

What Risks Are Different for Mergers in 2016 and Beyond?

A significant risk factor for hospitals contemplating an affiliation in 2016 and beyond is the growing likelihood of an eventual change of control at the partner level. Mergers between multi-billion-dollar non-profit and for-profit systems indicate that greater scale does not protect against a downstream change of control. Affiliation terms should be negotiated with this probability in mind.

The durability and sustainability of any partner's strategic vision are likely to face significant stress as a result of forces that are roiling the industry and most markets. The impact of mergers on health care costs continues to receive scrutiny by regulators. In addition, anti-trust matters have become a larger factor in more contemplated mergers.

Hospitals vetting merger partners should continue to closely examine strategic alignment, cultural fit, and how the proposed merger addresses organizational needs and constraints around access to capital, scale, and access to expertise and management systems. In addition to those areas of investigation, it is vital to vet how well potential partners demonstrate value through quality and efficiency. Does the partner have a track record of exporting higher value performance to affiliates? It is also critical to engage partners around how they attribute value within global budgeting and/or risk sharing arrangements. Is value attribution well-defined and transparent? How does the partner attribute covered lives within the system? Will the affiliate's investment in an aligned primary care base be treated as a revenue center or a cost center by the affiliate? And does the affiliate have the expertise, systems and resources, and demonstrated value proposition to succeed in a full population health payment environment?

Preparing for the Worst

When developing the architecture of a merger through the final negotiations of the definitive agreements, it is essential to include provisions that will provide a road map and define how key issues will be handled. There is no way to envision all eventualities, but some of the most important topics for consideration include:

- Exit Provisions: Unilateral, duration, and for what cause(s).
- True-up at Termination: Provisions for accounting for cash flow losses, investments (net of depreciation), assumption of debt and operating cash generated locally, and any break-up fees.
- Timing: Notice of termination should ensure the affiliate has adequate time to transition and retains access to critical resources/services at fair cost for a reasonable period of time.
- Delegation of Authority: Once notice of termination is provided, affiliate assumes operational authority to implement operational improvements.
- Access To and Use of Consultants: Once notice of termination is provided, affiliate retains access and use of all consultant studies procured during affiliation.
- Replacement Partner Selection: Once notice of termination is received, decision rights regarding finding a replacement partner in advance of termination date are held solely by affiliate.

There are no risk-free options, and a failed affiliation post-consummation is a messy and costly affair. Regardless of your chosen path, the case studies and findings presented in this article can help to prevent worst-case scenarios, keeping your hospital on the safest possible "flight path" toward achieving your strategic objectives. ◆