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

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Hospital and health system boards are in a difficult position. The business of governing acute care health systems has become increasingly complex in recent years as board governance and industry structure have lagged.

The sector has evolved from a strictly charitable function to a major industry that comprises 5 percent of gross domestic product (GDP). The business is capital-intensive, highly regulated, technology-driven, and, most importantly, its outcomes impact people's lives.

The United States spends a multiple of what other industrialized nations do on healthcare, and yet our system is subpar. The World Health Organization ranks the U.S. first in spending but 37 overall. The index used is a blend of life expectancy, speed of service, quality of amenities, and other elements that we like to think of as readily accessible in the U.S. Countries that rank ahead of the U.S. include Greece (14), Colombia (22), and Dominica (36).

Some point to the level of ownership fragmentation as one of the causes of our over-priced, underperforming system. The hospital industry is composed of tiny companies compared to similarly sized sectors of the economy. In other industries like managed care, airline, auto, food and beverage, and tobacco companies, for example, the 50 largest companies hold market shares in excess of 75 percent. Yet the 50 largest hospital companies together command less than 25 percent market share. The hospital industry has no "large" companies and none have full access to capital—commercial paper markets, equity markets, debt markets, synthetic markets, foreign listings, etc.—like major manufacturing companies do.

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Healthcare reform and other macroeconomic initiatives are designed to promote efficiency, in part, through the stimulation of larger healthcare 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 U.S., there are well over 2,000 "companies" delivering care. With such fractured ownership, population health, as well as standardized, coordinated care, has been an elusive goal.[1]

Boards around the country are grappling with these issues and evaluating business combination opportunities more than ever before. In our experience, most receive good input on the general trend of consolidation, but weak input on the full range of strategic alternatives that exist and the processes and tactics that can identify and realize the board's desired outcome—typically the long-term security of high-quality, efficient care across a broad range of desired services for the community.

The focus of this special section is to describe the types of structures that hospital systems are utilizing in business combination transactions where some portion of ownership and control are exchanged. While we cover the full range of structures, we have focused on those where significant innovation has occurred. From our experience, most management teams and boards nationally are not well informed of the availability, implications, or nuances of many of these structures, which include:

1. Seller joint ventures
2. Buyer joint ventures
3. Multi-party joint ventures
4. Minority joint ventures
5. Consolidation transactions
6. Membership substitutions
7. Creative asset sales

For each structure, we will provide a description of the model, list common applications, the types of companies that have entered into the transaction form, and review the associated pros and cons. Within the description, attention will be devoted to the extent to which some or all *ownership* and some or all *control* have changed. While it is important to develop an understanding of these structures and their relative merits, we caution that it is usually a mistake to pursue a structure instead of a set of well-defined objectives. Our clients regularly expect to prefer one structure over another at the outset of a process, only to be surprised later that another structure better meets their needs. The most common error in hospital

1 For more information, see James Burgdorfer, et al., *Hospital Consolidation Trends in Today's Healthcare Environment* (white paper), The Governance Institute, Summer 2010.

transactions is solving for a partner or a structure from the boardroom instead of keeping an open mind and pulling the best partner and structure from the market.

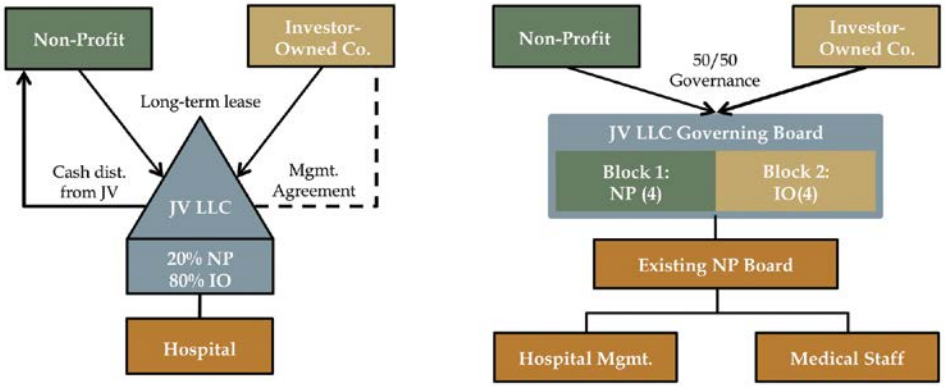
1. Seller Joint Ventures

Seller joint ventures (SJVs) are typically formed between a community hospital and a for-profit, 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 block voting on the joint venture board. Unusual to SJVs, the percentage of ownership does not follow control.[2]

Two requirements for an SJV to work are that the selling board must: a) have a modest level of financial leverage such that selling a 60–80 percent share of the business is sufficient to retire 100 percent of the liabilities, and b) have modest future capital needs, as the selling party will be responsible to fund their pro-rata share (20–40 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**.)

Seller joint venture transactions are typically entered into by stronger, proactive sellers who value future governance involvement. The value of this future governance involvement can be determined with precision as it's typically the notional 100 percent sales price multiplied by the ownership percentage retained. So for a $200 million, 80/20 transaction, the forgone value exchanged for retaining a minority equity interest (but still 50 percent of the board) is $40 million. There is generally no control premium. As one can see, it takes significant belief in one's future involvement (i.e., forgoing $40 million) to justify this model.

Exhibit 1: Seller Joint Venture Structure



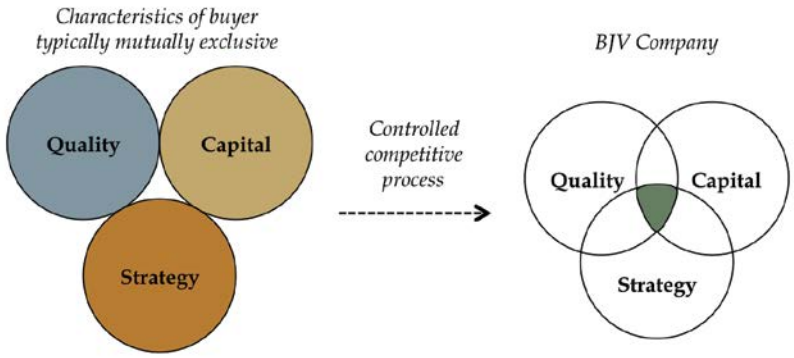
An example of a project we advised that took this form occurred in Hancock, Michigan, in 2013. Portage Health is a $100 million revenue hospital in the Upper Peninsula of Michigan. Portage was in good financial condition—the organization had a new hospital, low leverage (37 percent debt-to-capital), high liquidity (200 days cash), good margins (10 percent EBITDA), dominant market position, and a strong relationship with Michigan Technological University. The Portage board decided to implement a controlled competitive process to evaluate business combination opportunities and attracted a number of strong alternatives.

Given Portage's proactive, forward-looking orientation and capital structure, an SJV made sense. The board entered into a transaction valued at over $100 million, retained a 20 percent equity interest, and created a $40 million charitable, grant-making foundation for the community with the proceeds. The Portage board has retained a 50 percent governing interest with a blocking vote—so no services can be cut or major decisions implemented without local support.

A significant detractor of the SJV is its complexity. All possible future scenarios must be accounted for in the agreement and reflected in puts, calls, rights of first refusal, and other "optionality" provisions. Therefore, the legal agreements are significantly longer and more involved than selling 100 percent of the assets or stock of the business. A seller joint venture is an example of a structure in which partial ownership (usually 60–80 percent) changes and governance is shared 50/50.

2 For more information, see James Burgdorfer, "Whole-Hospital Joint Ventures between Non-Profit and For-Profit Companies," *E-Briefings*, Vol. 7, No. 2, The Governance Institute, March 2010.

Exhibit 2: Buyer Joint Venture Structure



Boards that pursue seller joint ventures tend to have several characteristics in common. As described above, the structure favors organizations with limited capital needs and strong balance sheets. The structure also forces boards to recognize the value they are placing on continued local control. Often, the buyer will have made two offers—one for an SJV and another for an outright acquisition. By choosing the SJV, the board knows exactly how much value it is placing on its continued governance role in the organization. The SJV, therefore, appeals to those boards that place significant value on an ongoing role at the parent governing level.

2. Buyer Joint Ventures

Buyer joint ventures (BJVs) combine the respective expertise of a clinical partner and an equity-sponsored system. The clinical partner holds a minority of the equity interest (typically 3–20 percent) and is responsible for overseeing medical safety and quality. The investor-owned partner provides capital (typically 80–97 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.

This structural alternative is a relatively new phenomenon and was not an option for selling boards to consider prior to a few years ago. Selling boards we have advised 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.[3] (See **Exhibit 2**.)

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An example of a BJV transaction Juniper recently completed was in Johnstown, Pennsylvania. Our client, Conemaugh Health System, is a three-hospital, $500 million revenue system in the west-central part of the state. Since 2011, the system had tried various ways of coming together with a regional partner. Ultimately, the board recognized that it would not be possible to receive the significant capital investment and quality improvements it desired without a structured approach. Juniper was asked to design and manage a process for the board to assess the full range of alternatives. At the completion of the competitive process, Conemaugh selected a joint venture between Duke University and LifePoint Hospitals.

Duke will be responsible for overseeing quality, safety, and clinical protocols. Duke does not anticipate receiving any referrals from Pennsylvania to North Carolina but, instead, has the corporate objective of providing rural areas with quality protocols they have developed as one of the country's leading academic medical centers (i.e., expanding brand strength and reputation).

LifePoint, a publicly traded hospital company with over 60 hospitals in 20 states, will be investing over half a billion dollars in the region. This is intended to help Conemaugh grow services and specialists, and construct new facilities. With the decline of the steel industry, Conemaugh is now the leader of economic activity in the west-central Pennsylvania market. As such, the board sought to grow employment, attract business, and put the local construction trades to work. This is the largest rural transaction in history. Interestingly, the economic consideration includes a stock option component that will allow the resulting Conemaugh foundation to participate in the future success of the BJV in the region.

The BJV model is similar to an outright sale in that full ownership and control are exchanged.

The Conemaugh Health board of directors will stay in place but shift to an advisory rather than fiduciary role. In addition, the chief medical officer of Duke will have a seat on the Conemaugh board to help oversee quality and safety. The resulting charitable foundation will net more than $100 million and will obviously take on a larger and more prominent role in the community.

3 For more information, see James Burgdorfer, "Hospital Joint Ventures between Non-Profit and Investor-Owned Companies: Uses and Future Applications," *E-Briefings,* Vol. 9, No. 6, The Governance Institute, November 2012.

3. Multi-Party Joint Ventures

Multi-party joint ventures (MPJVs) combine the characteristics of the previous two structures—essentially an SJV plus a BJV. This model enables the involvement of a clinical partner, capital infusion, and preservation of local control. While complex in execution, the structure has been implemented in a handful of settings around the country.

MPJVs lend themselves to an emerging, but yet to be realized, development in the non-profit hospital industry: the Integrated Foundation Model. This structure, developed by Juniper in concert with a former community hospital board member, allows community hospitals to maintain meaningful local control while accessing improved operating, clinical, and quality resources, and monetizing the asset.

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.**)

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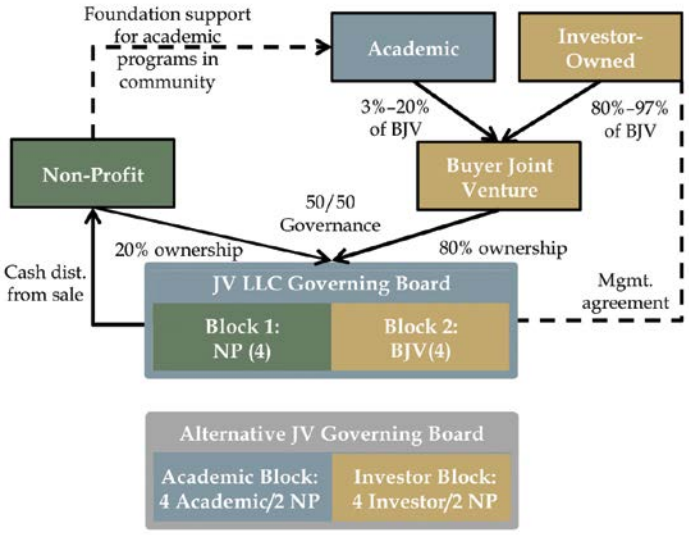
The MPJV structure is designed to protect the non-profit tax status of the local and academic partners, while leveraging the capital structure of the investor-owned partner. In this model, a well-capitalized hospital enters into an MPJV with an academic medical center or strong regional system and an 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.

Exhibit 3: Integrated Foundation Model Structure



4. Minority Joint Ventures (Nibble Strategy)

Separate and distinct from SJVs, as defined here, are minority joint ventures (MJVs). The structure is known in the corporate arena as the "nibble strategy," 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.

> Consolidation transactions are difficult to execute but typically double the size of the individual partners, quickly achieving scale. Today, scale is seen as a necessity for population health and accountable care risk-taking.

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.

5. Consolidation Transactions

In a consolidation transaction, two parties combine to create a new parent company with a self-perpetuating board. This was a very popular structure in the 1990s and has seen a revival post-health reform. Consolidation transactions created many of the larger national 501(c)(3) systems including Advocate Health Care in Chicago, Banner Health in Phoenix, and Sentara Healthcare in Virginia.[4]

Consolidation transactions are difficult to execute but typically double the size of the individual partners, quickly achieving scale. In the 1990s, the need to create scale was promoted by the threat of managed care companies commanding pricing power. Today, scale is seen as a necessity for population health and accountable care risk-taking. To work, consolidation transactions 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 CEO—because generally both boards combine into one. Although hard 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.

6. Membership Substitutions (Stock Sale)

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 acquirer, who becomes the new "member." A recent corporate comparison would be Berkshire Hathaway's acquisition of Heinz. Of the two ways in which control of a company can be acquired, either by purchasing the assets of the company or its stock, Berkshire chose

4 For more information, see James Burgdorfer, Jordan Shields, and Rex Burgdorfer, "Consolidation Transactions: Will They Make a Comeback?" *E-Briefings,* Vol. 8, No. 4, The Governance Institute, July 2011.

the latter. This is typical in public company transactions where shareholder approval is needed. The structure is used in non-profit transactions where the seller wants its corporate shell to remain intact post-closing, or the buyer wants to assume, rather than retire, the liabilities.

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 historically not 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. This increases the number of viable partners for boards to consider. Membership substitutions also typically involve forward-looking capital commitments, where the non-profit 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.[5]

In many cases, systems are now crossing state lines for strategic partnerships. This increases the number of viable partners for boards to consider.

The acquisition of a hospital's stock, or a membership substitution, typically is a full change of ownership and control. The only caveat is that certain representatives of the target board are sometimes appointed to the parent company. This gesture demonstrates a commitment to the seller of the strategic importance of the region to the buyer. Membership substitutions represent the predominant transaction form. They can make sense for a variety of strategic and financial reasons.

7. Asset Sales

Asset sales are common between non-profit sellers and investor-owned acquirers. 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.[6]

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. Many of our clients have similar objectives and have elected to forgo a large purchase price that would be used to create a charitable grant-making foundation. Instead, they are seeking to maximize the future capital commitment that the buyer commits in the transaction. This is indicative of:

- **Scrutiny surrounding the use of future funds in a foundation**: They must be for the original purpose of the corporation but cannot "enure" the now for-profit hospital. These constraints limit projects the seller can pursue. Creating a foundation can make sense in certain circumstances such as: a local government seeking to monetize the healthcare assets through a privatization transaction (typically funds are then reallocated to different functions within the municipality), a religiously sponsored entity that is shifting or managing its portfolio (such as focusing on schools and senior living instead of acute care), or a shift in mission entirely (to exit the hospital business and enter the research business).
- **Increased costs to manage a foundation**: Administrative, legal, investment management, etc. make the proposition of future sustainability more challenging. This is particularly true in a low interest rate environment where conventional fixed-income instruments yield so little in annual interest.

- **Changed objectives**: As discussed, participants in business combination transactions are financially and clinically stronger. As a result, they are typically interested in or able to participate in the future healthcare network. In the past, defensive hospitals that sold relied on the acquirer for operations and strategy. As sellers now seek to "stay involved," the creation of a foundation and change in mission becomes less desirable.

Membership substitutions, or selling the stock of a business, have certain advantages to sellers related to simplifying the handling of funded debt in a transaction. Buyers, however, typically prefer to acquire the assets of the target as it limits future legal obligations, which are typically left with the seller. One benefit for sellers in asset sales transactions is that this structure can accelerate integration into the new system.

Conclusion

Maximizing the outcomes of each of these strategic options requires that board members generally understand the purpose and use of each structure and factors that may 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 in the post-reform industry.

The Governance Institute thanks Jordan Shields and Rex Burgdorfer, vice presidents with Juniper Advisory, for contributing this article. They can be reached at jshields@juniperadvisory.com and rburgdorfer@juniperadvisory.com.

5 For more information, see James Burgdorfer, "Why Are So Many Merger Transactions Failing to Close?" *E-Briefings,* Vol. 8, No. 1, The Governance Institute, January 2011.

6 For more information, see Rex Burgdorfer, Krist Werling, and Megan Rooney, "Hospital Merger and Acquisition Transactions: A Focus on Retiring Liabilities," *BoardRoom Press,* Vol. 24, No. 5, The Governance Institute, October 2013.