



ROUNDTABLE

Capital Finance: Industry Consolidation

Healthcare organizations' concerns about capital access and long-term viability are driving a boom in mergers, acquisitions, joint ventures, and other affiliations. Increasingly, these agreements result in nontraditional partners: nonprofits with for-profits, academic medical centers with investor-owned firms, faith-based systems with secular systems, and affiliations across the continuum of care. Ownership and governance structures also vary in terms of control. Today's healthcare leaders must base their M&A search on a host of factors, including capital access, local market needs, financial support, and growth opportunities—and the risk of being left out. Time and effort must also be invested in priorities after the merger or acquisition is completed. Careful planning around managing the business as well as direct and indirect relationships post-consolidation need to be near the top of every leader's to-do list.



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Roundtable Highlights

HEALTHLEADERS: *Why has consolidation finally taken hold so strongly in healthcare?*

JAMES OLSEN: The undercurrents began in 2008 with the financial crisis and the recession. At the time, many organizations suddenly had limited access to capital and stressed balance sheets as investment portfolios declined precipitously and pension obligations and other liabilities grew significantly. So as early as 2008 and 2009, many health system boards and management teams became more focused on strategic solutions and potential partnerships. By 2010, when healthcare reform legislation was passed, essentially all organizations were forced to engage in strategic dialogue to determine how their organization would reposition itself for success in the new era. We saw a major increase in the level of M&A activity in 2011–2012, and we think it's just the beginning of an enduring, five- to 10-year consolidation trend.

NINFA SAUNDERS: Organizations believe there are only three options available to them: Stand by yourself, be acquired, or acquire others. While mergers and acquisition dominate the consolidating market, many healthcare executives are pursuing strategic relationships along specific functional elements, including the development of primary and specialty care networks, and exploration of a shared service network.

ROGER DESHAIES: Vermont wants to be the first to demonstrate a redesigned healthcare reimbursement and insurance system. They want to be there in 2017, and a high percentage of our population is insured—about 40,000 out of 650,000 people are uninsured. The problem is going to be how you fund it. The number that's bandied about is \$1.6 billion. For a state like Vermont, that translates into an employment tax that would have to be around 15% or a state income tax that would rise somewhere around 20%, and

the state income tax is already the fourth largest. New Hampshire competes for Vermont business by taxing considerably less, so that's a risk. In our state, I'm not sure there's an option on anything less than a full corporate consolidation because we have 14 hospitals, seven of which are critical access. Strangely, the academic medical center is the cheapest place in the state for most services.

KRIS ZIMMER: Larger facilities can demonstrate scale efficiencies and smaller facilities can't. That's true within our system and across the country. Many smaller hospitals are able to stay afloat, but they're not able to reinvest in the future, so they're dying a slow death. We see some that have reached that point, but we see an awful lot that are making a go of it for now. But it's an interesting dilemma—socially, politically, and economically—as to what happens to them. We're getting calls from a lot of them, but it's once they are at panic mode. There's a debate about whether they're a strategic asset or strategic liability, and we've had to do a lot of discernment around that. The midsize group and a midsize standalone facility used to be very safe. But that's not the case anymore because they're unable to invest in the future, they're unable to develop clinically integrated organizations, and they're in an especially bad situation if they have competition. Those folks are struggling mightily and they're looking to link up with somebody stronger as quickly as they can. We're also in the midst of a radical transformation of our own organizations that brings risk.

HEALTHLEADERS: *So some organizations can afford to be cautious with this and some are in more desperate straits. We've heard about a 20% revenue decline bogey as the benchmark that folks are using to align their cost structure. Is that accurate?*

SAUNDERS: It tells me that incremental reduction is not going to get us where we

want to be. This compels us to build a system of care that allows us to manage the patient out of the hospital and into postacute and community-based care. The problem is timing. If done too fast, then resource optimization does not



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happen. We need to align closely with our partners, in particular the physicians. The physician-hospital relationship must align purpose, clinical processes, outcomes, and economic incentives. In addition, cost reduction must target care redesign with a focus on incremental changes and process improvement.

DESHAIES: In terms of a revenue decline of 20%, it's certainly not a number pulled out of the air. It relates back to the Medicare reimbursement rate. Medicare is becoming the standard, for better or worse. Medicare is about 80% of cost right now, roughly speaking, and so that's where the number comes from. Every single payer is looking at that as a standard. If they could implement it tomorrow, they would implement it. There's this sense that that's a doable thing. I'm not convinced.

OLSEN: As we look at potential mergers and acquisitions for our clients, we typically work with management teams to develop detailed financial projections.

The lack of transparency on future reimbursement and utilization makes the process more difficult these days. A number of our clients are modeling everything at Medicare rates as a base case. However, as we all know, future changes not only impact rates; we have to also consider the transition to completely different payment methodologies and potentially reduced volumes. In addition, we need to make assumptions for the shift from commercial payers to exchanges, and the pace of change will vary from market to market. So trying to predict future revenue is challenging. Clearly the industry is facing revenue pressure. It will be critical to do everything possible to bring cost structures in line with future revenues. Moving some care into lower-cost settings is part of the solution. It seems that all organizations are working to develop a comprehensive primary care network and enhancing clinical integration to align incentives and better manage costs. However, industry consolidation through mergers and acquisitions will play a key role in achieving greater operational efficiencies and reducing the cost of delivering care.



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DESHAIES: The reality is, if this thing is going to work and if there's a lot of excess capacity out there that's adding to the cost structure, you've got to see places go under. Before they go under, there's always this flurry of activity in trying to find a partner, when the reality

is that the key in acquisitions is to have some vision as to where you want to be in 10 years, because you really just cannot just respond to everybody coming knocking on your door. A lot of these small providers are in business lines not because it makes sense, but because the reimbursements for those business lines are disproportionate to reimbursements for other business lines where they are more capable of rendering quality care, such as emergency and nonsurgical services. You can't make money on those.

SAUNDERS: I am concerned about smaller hospitals and critical access hospitals needing an infrastructure that will support their clinical operations. There is profound need for physician and diagnostic services in both the emergency room and inpatient facility, yet resources are meager. One option is to convert some of these hospitals to 23-hour observation areas—essentially staging areas—and eventually transfer patients to a full service hospital. This is easier said than done. Many communities are passionate about maintaining a vibrant, local, full-service hospital. Unfortunately, scarce resources and declining reimbursement render this option unsustainable.

DESHAIES: But they lose the free ride with Medicare with the critical access status. So even Medicare, which claims that it's pushing the healthcare industry in the direction of health reform, is shoring up inefficiencies through its own policies.

SAUNDERS: You're trying to get this to the right care design. Many organizations, in particular for-profit organizations, have done a great job of reducing costs, optimizing their revenue stream, and developing a diverse portfolio that supports organizational agility and sustainability. Private equity firms' interest in the healthcare business has increased. The for-profit footprint in healthcare continues to expand as firms acquire and convert not-for-profit hospitals to for-profit entities. We must continue to understand and learn from the various care and business models throughout the industry.

ZIMMER: I agree. In so many situations we see an extremely passionate local board. Often the board is made up of city- or county-elected positions, and a huge part of what they were elected to do is protect the hospital. Sometimes we look at the situation and say what the community needs is that 23-hour observation—an outpatient facility. We've labeled ours "healthplexes," and they're phenomenal care platforms at a level that make sense in a rural community. In a few situations, we're actually telling them, "You need to let this thing die and we need to build a new one."

HEALTHLEADERS: *How receptive are they to that?*

ZIMMER: We've had some experiences where that's not what they want to hear. Often the best situation for us is where someone else has delivered that message, and we can come in afterward and help them rebuild.

OLSEN: These organizations are interested in survival, and they're willing to convert to for-profit if necessary to sustain their hospital and the services they provide to the community. That being said, a unique characteristic of current M&A activity is that more and more stable credits in the A category that are not distressed are thinking about their strategic options and finding strong partners. A number of these systems are taking the position that they don't want to get to the point of distress before they find a partner. They are being proactive, negotiating from a position of strength, and determining their own fate. This is a unique characteristic of the current period of consolidation.

HEALTHLEADERS: *What about competing government incentives on this question?*

OLSEN: We often discuss the fact that there are competing policies. On one hand, we have healthcare reform driving consolidation out of necessity to wring out costs, drive operational efficiencies, and bend the cost curve. On the flip side, we are seeing many

transactions being challenged based on anticompetitive concerns.

SAUNDERS: That's because in many ways this is not healthcare reform. It's a budget reduction. If it was reform, it would mobilize a different structure design and outcome. Yet the industry is so embedded with policies and regulations that it is difficult to change even if you want to redesign.

HEALTHLEADERS: *Have you ever had those kinds of issues scuttle a transaction?*

OLSEN: We have. But we think we do a good job of identifying potential issues up front as part of the process while we're evaluating potential partners. However, we suspect we'll be dealing with this issue a lot more going forward as markets and regions consolidate further. As far as antitrust scrutiny, the in-market strategic buyers generally can afford to pay the highest purchase price because of the greater potential synergies and opportunities. There is a strong tendency to want to merge with the strongest potential partner that ensures long-term future success for the combined organization in spite of the potential for greater FTC scrutiny.

ZIMMER: The key there is if you think about the fundamentals of why the antitrust legislation exists in the first place, it's really about monopolization and using that monopolization to gain excessive profit. Somehow we're going to have to address this issue of whether a larger integrated delivery network can truly promise cost savings and then be held accountable to that. And we think the answer is yes; it's just really hard to get the government to take that leap of faith.

DESHAIES: It's not just the FTC. Some of the bigger challenges are some of the less obvious ones like, for example, doing business across state lines. We're also in New York, and we have found laws and regulations on the books that don't make much sense. For example, you cannot have an out-of-state entity running the obligated group, which is

counterproductive to facilitating capital formation. That, in itself, is a big deterrent. In New York, as well as in Vermont, they are very strict on for-profit equity partners. There's a lot of barriers before you even get to the FTC that could actually make it very difficult to extract real value out of a deal.

HEALTHLEADERS: *That said, deals are still getting done. How competitive are they?*

OLSEN: It's generally very competitive, even when it's a distressed situation. There tend to be more for-profits involved in the distressed situations. Nonprofits generally avoid the more distressed situations because they are highly focused on the dilutive impact to their credit. However, generally, we can count on between five and 10 interested parties in any sales process. Given this high level of interest from the market, we are typically successful in obtaining meaningful contractual commitments from buyers related to capital, maintenance of services, etc. Recently I was involved in a highly distressed situation, and ultimately there were three for-profit companies who submitted competitive bids. In these situations, the for-profits will operate the organizations very differently going forward, and it is important to manage expectations appropriately.

HEALTHLEADERS: *What about prices? Are these deals, to borrow a phrase, getting to be irrationally exuberant?*

OLSEN: In some cases, yes, but generally purchase prices remain rational. Some acquirers have sufficient capital to pay a premium. In addition, today's cost of borrowing is at all-time lows. So some acquiring entities can lever up and pay a premium due to their low cost of capital. That being said, multiples are relatively low from a historical perspective, and they have been low for some time because of the uncertainty about the future and the inherent risk.

ZIMMER: My perception is that with private equity dollars, there's either too much of it or not enough of it within

a particular segment, and in healthcare there's a lot right now and in part it's because of the short-term opportunities. My sense is the other part is there just aren't many better options right now, and I'm assuming that is somewhat cyclical. Is that private equity availability here to stay, or is it likely to be cyclical?



OLSEN: It's mixed. It is cyclical, and it is driven by the fact that there is significant capital available and the fact that we have a massive industry going through significant transformation, creating a unique investment thesis. The investment rationale is based on the availability of capital to deploy, all-time low borrowing costs, opportunities to acquire assets, and the ability to take advantage of the current consolidation trends to drive synergies and operational efficiencies. They also have access to experienced management teams. Other macro considerations are that the healthcare industry as a whole is very large and growing—20% of national GDP by 2020—and the demographics are good. With a five- to 10-year horizon, these companies have the potential to be very successful in the current environment.

SAUNDERS: If you look at the maturity of this trend, it is not well developed; it's still siloed. Healthcare is not well integrated clinically, so there's plenty of opportunity. For instance, we are trying to look at homecare in a different

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way—that's not a space where we have the best competencies. If there are retail firms that understand how to manage and integrate this aggregation of services and they are comfortable with developing a good business construct, then that would be a partnership worth pursuing. We should not shy away from partnerships with physicians, but also with for-profit organizations or even payers. At the very least we should explore, learn, and listen.

ZIMMER: It's a question of the best use of capital because capital is limited for everyone—I don't care how strong your balance sheet is, it's a limiting factor. There are for-profit niche firms that can be very successful within their area of expertise. The risk is whether we can get proper alignment with organizational goals. We've seen many situations where, for example, in a wound care program or a rehab program, where you think you have alignment up front, but over time you realize that you really are at cross purposes and that the outside entity's primary focus is drawing revenue streams out of the organization, not for overall better healthcare at a more efficient cost.

DESHAIES: If you really view it as fact that fee-for-service medicine is going by the wayside, it could conflict with some of the for-profit models out there because some of them are heavily fee-for-service driven. I've seen some really good niche players out there. But once you aggregate care under some form of population-based payments, I could see where you could get into some conflicts with the for-profits.

HEALTHLEADERS: *We've been through waves of consolidation in targeted fields in this industry before. What feels different this time?*

OLSEN: The last wave of consolidation was in the late '90s when we saw the formation of integrated delivery systems, regional systems, and large multistate systems. At that time, the strategic rationale was primarily in response to managed care—consolidating for

greater leverage in negotiations with insurers—and less about achieving operational efficiencies. This time we know there are pressures on reimbursement, utilization, and volume. The current M&A trend is more about bringing cost structures in line with revenues and enhanced clinical integration. Physician acquisitions continue to be active. Also, hospitals and health systems are going through the process of determining whether or not they want to own across the continuum of care or if they want to focus on certain services and partner with strong organizations to provide other services.


ZIMMER: It's a huge question because strong systems are at a fork in a road where the question is whether the priority is to preserve the debt rating or to invest in a strategy. Many not-for-profit systems are somewhere between A+ and AA rated and take great pride in that, us included. Is that something we should be holding on to, or are we underserving our mission by hanging on to that balance sheet strength?

OLSEN: Our clients often wrestle with the issue of pro forma credit ratings when they are considering an acquisition because nine times out of 10 the acquisition has a dilutive effect on the credit and the balance sheet. Ultimately, however, one of the key reasons these organizations have built strong balance sheets and maintained AA credit ratings is precisely to take advantage of these strategic opportunities. These potential mergers or acquisitions often present an opportunity that doesn't come along often. The industry is going through a dynamic period. In many situations these transactions will determine the endgame in the market or region, and if your organization is not successful, it may never have the opportunity again.

SAUNDERS: Both of you are absolutely right. That's the reason you save the money. The problem is there are so many competing priorities that you don't know the right sequencing.

Executives and boards are concerned about dilution of the organization's financial position. The balance between growth and financial containment is one that we have yet to master.

ZIMMER: There is good news in that the rating agencies are working hard to get ahead of this curve. Each of them has released reports in the past several months talking about the issue. They understand that large physician clinical practices and risk-taking functions, managed care entities of sorts, have different ratios than hospital systems. In the conversations I've had with some of the large funds that own a lot of our tax-exempt bonds, they are very focused on strategy, and regardless of rating, they are looking for organizations that have a vision and a plan and will prioritize those organizations over ones that are hoarding cash but sitting still.

DESHAIES: We are in a mature industry, which means the mature players have a lot of cash. They have a lot of expertise on making money doing what they have traditionally done, but their biggest vulnerability is their biggest strength. It's difficult to take the risk of moving back down the curve in another, different way. We've seen a lot of examples of that in other industries that have successfully made that transition. We've also seen businesses just riding the obsolescence curve right into the ground. The healthcare industry is very much in that mode right now. The wealthy and the successful are perhaps the most vulnerable because they're the most attached to what they've always done, and they've become very good at it. But the asset base will become the attributed life. You could have all the cash in the world, but if you don't have attributed lives, you're Xerox telling the market that you don't need to get into PCs. You're making a fundamental mistake because of your market position, your market dominance, your wealth, and your credit rating. The asset no longer is what you always thought it was going to be. 

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