TO MERGE, OR NOT TO MERGE: A QUESTION OF SURVIVAL IN THE NEW MILLENNIUM OF HEALTHCARE DELIVERY

JOHN R. WASHLICK
COZEN O’CONNOR

PHILADELPHIA, PA

Introduction

This article will explore some of the decisions hospital and health systems need to consider when wrestling with the question, “to merge, or not to merge.” Most of the criteria that hospital officials typically deliberate are not necessarily legal, but are more business and not all of the business factors are even based on financial performance. In fact, when it comes down to developing long-term strategy, hospital boards should almost feel compelled, as part of their fiduciary obligation, to review merger, consolidation and other formal affiliations, to assure that their institution can adapt to growing challenges and respond with the appropriate delivery scale necessary to serve its patients and communities.

Background

There has been a flurry of hospital and health system merger, acquisitions and consolidations in the past few years and industry experts are not predicting an end to such acquisitive activities anytime soon. This, of course, to healthcare transaction attorneys and advisers is good news. In fact, when the final numbers are all in, Becker Hospital Review reports that the number of mergers and acquisitions in 2011 is on track to be the highest in the past decade.1 Becker predicts that this growth trend is expected to continue in 2012, driven, in large part, by provider responses to the challenges and opportunities created by national and state healthcare reform initiatives.

Hospitals seem to be scrambling to search for the right model that will best position them to thrive under a reimbursement model that will reward efficiency and integration.2 To many

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hospitals, the decision to enter into the merger arena is not an easy one. In deed, some hospitals may be forced to enter the game out of sheer necessity to survive in today’s competitive market. These woes are compounded by extreme reimbursement cuts by the federal government and a shift from volume reimbursement to innovative value-based payment methodologies that have hospital officials scrambling to figure out their nuances and whether or not they have the appropriate infrastructure to even participate in these initiatives, let alone prosper under it.

Hospitals that haven’t adequately prepared for the move toward integrated care and bundled payments could find themselves looking for an acquisition, merger or other type of affiliation.³

It is worthy to point out that the flood of recent merger and strategic partnership transactions should not infer that independent hospitals are doomed. However, some investment banking representatives predict that fewer independent hospitals will survive through 2012 without striking some type of deal with a larger healthcare system.⁴ They support their claim by pointing out the unprecedented forces bearing down on independent hospitals that were not present during the merger-era of the 1990s, such as, declining patient volumes and reimbursement, increased quality requirements, increased clinical and operational IT requirements, increased capital demands related to physician affiliations and employment, increased credit costs and increased demands on management.⁵

**Factors Driving Mergers and Consolidations**

There are a number of consistent factors cited by hospital officials of why they consider merging with another entity. Many are subjective, while many come down to the “black and red” financial condition of the institution and its ability to go it alone in the face of market, regulatory and capital challenges.

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³ Id.
⁵ Id.
1. **Access to Capital**

One of the most significant factors that weigh heavily on whether a particular hospital may find itself the target of an acquisition versus a strategic buyer turns simply on the amount of surplus capital the institution has on hand, or has access to, so it can meet its immediate operational needs and projected future long-term costs. While many hospitals may have sufficient cash on hand to meet its current working capital needs, they may not have enough retained capital (net assets) adequate to replace current buildings and equipment. The demand on capital to strengthen, update, or even replace physical facilities is a leading factor that drives many independent hospitals to consider merging with a more financially sound partner, and often a larger integrated health system.

2. **New Service Lines**

Many hospitals seek a strategic partner in order to expand needed services not presently available to their patient community. In this regard, many independent facilities seek larger health systems as partners. These healthcare systems often offer strong and stable networks of hospitals, physicians and ancillary care services that afford a more integrated range of services over a broader geographic area than the independent hospital could provide on its own.

3. **Expand Market Penetration**

Of course, as hospitals expand through acquisitions and other alliances, careful attention must be given to comply with federal and state anti-trust laws. In some cases, regardless of the intent of the parties, planned mergers may simply fail because of anti-trust concerns. For instance, when ProMedica Health System of Toledo and nearby St. Luke’s Hospital decided to merge, the FTC intervened and argued that the merger would unfairly monopolize the Toledo market, in particular the FTC argued, the combined enterprise would raise its share of inpatient obstetrical services market to 80 percent. At the time St. Luke’s was financially struggling and ProMedica, a $1.7 Billion chain with 11 hospitals in Ohio and Michigan was poised to rescue St. Luke’s with a $35 Million.7

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7 Id.
4. State-of-the-Art Technology

In order to stay competitive, many hospitals need to keep up with the fast pace of technology so they can maintain a minimum level of necessary services. Technology needs expands beyond medical equipment and devices, but also includes information technology. Hospitals are hard pressed to come up with the tens-of-millions-of-dollars necessary to construct and maintain the information technology infrastructure sufficient to comply with the federal government’s move toward electronic medical records (“EMR”). The push for EMRs in intended to create provider-to-provider connectivity so that participating providers can have as close to real-time reports as practical so that they can make quick and informed medical judgments that will hopefully yield better quality outcomes.

5. Respond to Competition

Successful mergers should result in a win-win for both parties, including the “target” enterprise that may have decided to seek a merger partner out of sheer lack of capital necessary to provide state-of-the-art services and technology to their service community. A good example of a win-win result involved North Shore-LIJ Health Systems and Lenox Hill Hospital in Manhattan, NY. North Shore identified a weakness in its market penetration in the Manhattan market. As a result, North Shore targeted Lenox Hill Hospital in Manhattan as a strategic partner and proposed a merger in 2010. The transaction gave North Shore a foothold in the Manhattan market while providing Lenox Hill with needed capital and scale.8

6. Non-Financial Factors

Once a hospital decides that it will consider a strategic partner for all or any of the financial reasons discussed above, and many more others not discussed, most boards must consider the following non-economic factors before deciding “who” is the right strategic partner for their operation.

• Governance – In many cases, the seller will try to maintain a continued presence of the acquiring organization’s governing board or on the board of the selling hospital if it is to

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stay in tact. This can be a hotly contested point when negotiating the acquisition or merger agreement, but depending on whether or not the seller has any leverage, the eventual decision of how many, if any, of the seller’s board members will have any role with the acquiring health system’s governance is pretty much in the hands of acquirer. “To the victor go the spoils.”

However, there are occasions, when the buyer hospital that is looking to expand into a new geographic area will want to maintain a certain number of the board members of the seller. This may be the case where the buyer is trying not to come across to the community as nothing more than a carpet-bagger. Maintaining a certain number of board members from the seller entity can afford the buyer that instant credibility within the community that it may not otherwise be able to replicate without the continued presence of community members from the seller.

• Cultural Issues – Combinations of religious, secular or public and private institutions often face numerous legal challenges when it comes to approval from either regulatory agencies or religious authorities. Perhaps more critical to the parties involved, is that these affiliations potentially create a clash of cultural mind-sets and practices. For example, the relationship struck by Reston, Washington-based Providence Health & Services and Seattle-based Swedish Health Services led to a rather complicated strategic partnership intended to accommodate the parties’ unique cultural differences and missions. The combined structure permitted the 27 Providence hospitals to keep its Catholic mission, while the five Swedish hospitals stayed non-religious.9 The partnership was considered groundbreaking because of the preservation of their respective identities and religious affiliations. The systems share the Epic electronic health records platform, which allows them to join forces on population health management and, the parties hope, will also help drive the standardization of best practices among the participating providers.

• Workforce – If the merger or acquisition target has a workforce that is represented by a trade union, the negotiations may be further complicated by having to deal with any bargaining agreement that may be in place between the institution and the union. A bargaining agreement may even have provisions that are triggered that need to be addressed in the event of a change in control transaction.

Even if there is no union involved, a number employee issues must be addressed. For example, some key factors to consider are whether there are any golden parachutes that may discourage a would-be suitor from proffering a bona fide offer. Also, out of loyalty to the current workforce, there may be a desire by the seller to retain their employees, while the buyer may be seeking for opportunities to eliminate any duplication of resources as a means to offset part of the acquisition costs.

• Maintenance of Mission and Service Line – Whenever there is a combination of for-profit and not-for-profit institutions, there is always concern that the for-profit will discontinue certain services that may not be generating a profit, but were carried on by the not-for-profit because it was part of its charitable mission. A for-profit does not have to pay as close attention to providing certain loss services to a particular segment or geographic area of the community. The for-profit may make many decision on whether to continue a certain service line based strictly on financial measurements, that is, is it profitable or not; whereas a not-for-profit hospital may decide to continue a loss service in strict obedience to its charitable mission and its underlying commitment to the Internal Revenue Service as a condition of federal income tax exemption, irrespective of whether or not the service is profitable, or ever will be.

The Alternatives

• Strategic Alliances and Affiliations

Many hospitals are committed to maintain their independence but have added needed clinical and support services through strategic alliances with other healthcare providers. There are a number of recent examples of hospitals that have decided to forge strategic partnerships with other health systems, rather than “sell out.” These organizations arrived at these strategic partnership solutions only after their boards judiciously and thoroughly explored their institution’s individual needs, as well as their ability to provide the necessary medical and health services to their respective communities. If carried out correctly, a strategic affiliation can benefit both parties and successfully deliver a broader scale of medical and health services to the community, without having to cede control over the organization to do so.
For instance, Bayhealth, Inc., located in Delaware, recently formed a clinical affiliation with the Hospital University of Pennsylvania (“HUP”) to access cancer, cardiology and other highly complicated service lines that Bayhealth was not otherwise able to provide on its own. As a result, Bayhealth also now receives from HUP, surgeon recruiting assistance, education opportunities and clinical consulting, in return for which HUP now receives referrals from Bayhealth for services that Bayhealth is not capable of providing directly.10

In addition to community access to new services and modalities of treatment, one advantage of a strategic alliance is that the institutions involved do not lose their individual identity or relinquish governance of their organizations. Other benefits of many strategic partnerships include sharing of electronic resources, clinical data, best practices and administrative services. In many cases, hospitals can reduce the cost of duplicative services while solidifying their ability to meet the needs of providing the full continuum of care to their patient population.11 This can be accomplished without each of the parties having to invest significant capital by sharing the cost to expand services and shore up infrastructure in partnership.

Hospital and physician alliances may also make it easier to build an effective Accountable Care Organization (“ACO”). The transition to an ACO will be easier if the alliance partners are already sharing data, best practices and coordinating care.12 In the end, parties that are able to create a mutually rewarding partnership and where they have effectively combined clinical services and coordinated care between or among them, may actually be great merger partner someday. So, the affiliation could be seen as the engagement period leading up to an eventual marriage of the affiliated parties.

•  Clinical Co-Management Agreements

In some cases, a hospital may identify a certain clinical area that it wishes to improve or to develop but it does not have the necessary resources to go it alone. A clinical co-management

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10 Id.
agreement creates a mechanism for hospitals to partner with physicians to jointly provide key hospital services and improve patient quality outcomes. Co-management arrangements are by designed intended to recognize and appropriately reward participating medical groups/physicians for their combined efforts in developing and improving quality and efficiency of a particular hospital service line.

The arrangement may cover inpatient, outpatient, ancillary and/or multi-site services. Under a typical arrangement, the hospital and physicians have shared involvement in the daily operations of a particular service line. Co-management agreements are a great resource for hospitals to put in place as a mechanism to align physicians and the hospital to jointly manage quality and operational outcomes by making the participating parties accountable and rewarding each for achieving favorable operational results and quality outcomes.

Today, there is emerging a trend of co-management arrangements to include multiple specialties at multiple inpatient and outpatient locations across the country. The intended effect of these multiple party co-management arrangements is to impact outcomes positively across the entire continuum of care. If successful, this partnership between the hospital and physicians will compliment the current industry trends of hospital consolidation and accountable care organizations.

Conclusion

This article discussed business and subjective factors that boards across the United States are struggling with, and should be struggling with, as they self-examine their individual institutions to determine if they can successfully compete AND deliver healthcare services to the members of their service communities. Not just the delivery of services today, but next year and in ten years. After studying relevant demographic projections, most hospitals and health systems will eventually conclude that they have to grow or partner with another provider to meet current and future demands for healthcare services. But, the fundamental question that all providers must address as they head down this road is, “How to grow appropriately.” A miscalculation of “how” to grow now in preparation of the portended new healthcare business climate could doom an institution in the very near future.