

SURVIVAL STRATEGIES FOR COMMUNITY HOSPITALS

Recession, the credit crunch and reform have increased uncertainty and volatility in the health care industry. In response, community hospital boards are examining their strategic direction and realizing that the usual options are no longer viable. This article examines the market forces that will change the way in which community hospitals and health systems will operate in the coming years and provides insight into some of the strategic options community hospitals might consider in response.

The Burdens of Change

The common themes in the reform legislation—costs, quality and accountability—will put an undeniable squeeze on community hospitals. They will need to cut costs, increase efficiency and quality, and become more vertically integrated with physicians. They also will need to increase transparency in their clinical performance and report on quality outcomes. These new burdens come at a time when the three leading bond rating agencies cite familiar challenges for community hospitals: declining volume, increasing bad debt, shrinking Medicaid payments and changing models of Medicare reimbursement.

“Doing more with less” will prove particularly difficult for community hospitals that already are struggling. Many are not large enough to capture economies of scale, do not have the ability to further cut costs and can’t defer further capital expenditures without losing market share. Their regional presence makes them more susceptible to the effects of reductions in Medicare and Medicaid because they are unable to spread costs

throughout a larger geographic area. Commercial insurers faced with these same market dynamics already have begun to consolidate and in some circumstances may attempt to use their larger size to exert market pressure on managed care rates. Community hospitals faced with these challenges will need to adopt new strategies for survival.

Many Roads to Consolidation

The realities of the changing health care economy have energized community hospitals to re-examine their strategies for achieving their core mission. Usually the first step in the process is clearly articulating the charitable goals of the organization and then examining the options for meeting these charitable goals. In making these assessments, hospital boards often will determine and rank the importance of maintaining certain critical hospital service lines in the community; developing or expanding service lines or the physical plant to remain competitive in the marketplace; continuing or expanding physician recruitment initiatives;

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maintaining local control over the hospital; and ensuring that the hospital can keep its doors open in the future.

After making these assessments, hospital boards will then review their strategic options for achieving their objectives. Looking at these options through the lens of the new health care economy, many conclude that organic growth strategies and the development of additional physician partnerships will not be enough to ensure that their community hospital or health system will meet its mission objectives. This, in turn, leads to a broader analysis of strategic options, typically with the assistance of legal and financial advisors who assist the hospital in evaluating alternative paths.

Increasingly, community hospitals have been focusing on transactions with other nonprofit and for-profit hospitals to address their strategic imperatives. The trend toward hospital consolidation is not surprising in light of the changes in the field and the unconsolidated nature of the hospital industry. At last count, there were approximately 5,010 community hospitals operating in the United States, with the average health system owning 8.8 hospitals—a very unconsolidated service industry. With the increasing emphasis on cost and quality, consolidation is one obvious way to increase economies of scale and efficiencies in the delivery of a broader platform of services. Consolidation of a smaller hospital or health system into a larger system will likely reduce the smaller entity's cost of capital and allow it to maintain a strong negotiating posture with its payers and suppliers.

But hospital transactions are not all the same, and a community hospital that is considering this path should be aware of the types of transactions that may be available and the advantages and disadvantages of each.

The Member Substitution

The member substitution (also referred to as an affiliation or system joinder) refers to a transaction among nonprofit hospitals where one organization becomes the corporate member of the other hospital or health system's parent organization. From an accounting perspective, the balance sheet of the smaller hospital becomes rolled into the larger organization's consolidated balance sheet. The smaller hospital or health system receives corporate support services from the larger organization at a lower cost than it received prior to the transaction. Redundant services are eliminated or combined to increase the efficiencies and further reduce costs. In most cases, the larger hospital or health system makes a minimum capital commitment to the smaller organization, thereby helping to ensure that its capital needs will be met.

Many community hospitals and health systems viewed a potential relationship with one of their larger neighbors as a safety net that they could call upon if circumstances warranted. However, the idea that a larger health system "always will be there for us" is changing. Larger providers are being more cautious about entering into transactions, largely because of their own concern about maintaining a strong balance sheet and providing

HAPPILY EVER AFTER? NOT SO FAST

Even larger hospitals and health systems aren't immune to the twin challenges of the recession and reform. To protect themselves, they are thinking twice about forming relationships with smaller organizations and scrutinizing not only financial but quality data. Many smaller community institutions are finding that there are new hurdles that they must overcome in order to hold the attention of a larger nonprofit system. These hurdles generally fall into the following four categories:

No material financial dilution. Many hospitals seeking a partnership have capital needs that they cannot fund on their own. Almost by definition, a smaller organization's transaction with a larger system is a financially dilutive proposition for the larger system. If, given the size and credit rating of the larger institution, the nonprofit combination with the smaller entity would be so dilutive as to change the credit rating of the larger entity (thereby increasing its cost of capital) or taking needed capital resources away from projects that already have been earmarked, the larger system may not be willing to complete the transaction.

To help assess this dilutive impact, most hospitals will, as part of their due diligence of a potential transaction, conduct an efficiency study (which reveals the economies and efficiencies that can be garnered from a nonprofit combination) and a debt capacity study (which reveals the impact that a nonprofit combination will have on both organizations' borrowing capacity).

Aligned physician integration strategies. For a nonprofit

combination to make sense, the physician integration strategies of both organizations must be aligned. For example, if a larger system has made a decade-long commitment to developing an integrated multispecialty physician group, and the smaller hospital attributes much of its past success to its support of independent physicians, this becomes a potential barrier to effectively working together.

Economic efficiencies. Nonprofit combinations no longer can be seen as a means to insulate a hospital from change. Rather, a good collaboration will yield economic value with minimal investment. For the smaller hospital, this not only means accessing back-office economies of scale (for example, cost of capital, malpractice insurance, supply chain efficiencies) but scale opportunities that may also affect local employment (such as consolidating revenue cycle activities in the most cost-effective location). Potential partners also must be open to facility and clinical program rationalization.

No quality dilution. With the growing emphasis on quality and pay for performance, the quality component of due diligence is no longer limited to Joint Commission and malpractice exposures. Systems will determine if there is a material difference in quality based on a plethora of current and emerging benchmarks, and they will be hesitant to complete a nonprofit combination without confidence that any material quality concerns are not endemic and can be quickly and effectively addressed.—*D.B. and J.C.*

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the management resources necessary to meet the new quality benchmarks that health reform will bring. Consequently, many community hospitals and health systems are confronting unexpected roadblocks as they develop relationships with larger non-profit systems (see sidebar).

The Super-Parent Structure

Increasingly, nonprofit organizations of similar size and credit strength will decide to combine their operations as a means of driving efficiencies and economies of scale. Unlike the typical member substitution, however, neither entity will want to be perceived as the acquired entity, a situation which may drive a different transaction structure. Unlike a member substitution transaction in which a larger organization becomes a member of the smaller entity's parent organization, the super-parent model presumes that a new parent organization is created for both organizations. The parent organization is given reserved powers over the operations of both organizations, and its governing board typically is composed of an equal number of representatives from each constituent organization.

The super-parent structure may be most appropriate in two situations. The first arises when two health systems that serve adjacent service areas with minimal geographic overlap have collaborated on isolated initiatives over the years and have developed an institutional "friendship." These entities consider further integration as a means of achieving scale and redefining their markets together.

In the second situation, two hospitals in the same market area challenge the appropriateness of the "two hospitals, one medical staff" landscape that exists in many small cities. Many of these cities have experienced demographic and economic challenges at the same time that Americans use inpatient beds 50 percent less frequently than they did in 1980. The super-parent structure becomes a way to usher in a new era of community collaboration. However, federal and state antitrust laws may intervene if the two hospitals together hold a large portion of the market share in the community.

As part of the transaction process for creating a super-parent organization, each hospital will naturally focus on the financial health and creditworthiness of the other organizations. Because clinical integration and quality have become vital parts of the national health conversation, detailed due diligence is more important than ever. The two organizations will want to determine how the transaction would materially improve performance with respect to physician alignment, economic efficiencies and quality standards. Because core activities are affected, both parties will focus on forming a better, more efficient health system, leaving many current operating assumptions behind.

For-Profit Conversion

Unlike the nonprofit combination, a for-profit conversion transaction involves the sale of the assets of the system to a for-profit

purchaser. From a tax perspective, the sale of the hospital converts its status from a nonprofit to a for-profit entity and in most cases requires the approval of the state's attorney general. The community hospital receives a payment equal to the fair market value of its assets. After paying any outstanding bond debts and other liabilities, the residual proceeds of the transaction are held by a community foundation and administered for health care and other charitable purposes. The community hospital's board often continues to administer the foundation after the hospital is sold.

There is a common misconception that a for-profit purchaser of a hospital will have complete discretion over the assets and operations of the purchased organization. Instead, nonprofit community hospital and health systems frequently negotiate post-closing agreements that give the members of the nonprofit hospital's existing board some control over the hospital's operations after the transaction is consummated, particularly Joint Commission-related functions. If the hospital is structured as a joint venture with the for-profit purchaser (another common transaction structure), the governance role of the nonprofit board may be even more substantial. It also is very common to negotiate agreements that require the for-profit purchaser to make a minimum level of capital expenditures at the hospital following the transaction, including the completion of capital projects set forth in the community hospital's capital plans. These capital commitments usually are in addition to the purchase price paid by the for-profit purchaser for the community hospital. Other common agreements relate to commitments to maintain the organization as an acute care hospital in the community for a minimum period of time following the transaction or a guaranty that certain essential hospital services remain. Finally, not all assets need to be sold. For example, a health system may choose to sell an acute care facility but opt to retain discrete service lines, such as a nursing home or psychiatric hospital.

The Bottom Line

In the post-reform world, community hospitals and health systems must re-evaluate their core strategies for achieving mission goals. For some, this will mean completing a thoughtful review of potential transactions, in each case with a firm understanding of different transaction possibilities. For others it will mean getting creative, such as by vertically integrating with physicians in new ways or seeking tax support for their operations. And for others, it may mean a restructuring of their liabilities, formally or informally. Regardless of their size or circumstances, however, all community hospitals will need to respond to changes in the industry by changing their strategic path. **T**

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