



Presentation to  
Boston Municipal Analysts Forum

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# Navigant

*Presentation Team*



**Edward Casas**  
Sr. Managing Director  
(office) 847.583.1619  
ecasas@navigant.com

Dr. Casas serves as Senior Managing Director and Head of Navigant Capital Advisors. Dr. Casas has over 25 years of healthcare advisory experience. He specializes in operating and financial restructurings, corporate finance, mergers, acquisitions & divestitures, and strategic plan development on behalf of creditors, debtors, equity sponsors, third party purchasers and sellers.



**David Burik**  
Managing Director  
(office) 312.583.4148  
dburik@navigant.com

Mr. Burik heads the strategy and healthcare valuation practices. He has over 30 years of consulting experience within all segments of the healthcare industry. His expertise includes the definition and communication of key strategic issues, market and demographics, competitor analysis, as well as the successful execution of the solutions for those issues.



**Gregory Hagood**  
Managing Director  
(office) 404.504.2017  
ghagood@navigant.com

Mr. Hagood leads Navigant's Healthcare Investment Banking Practice. He has extensive transaction experience in the healthcare industry including hospitals, physician practices, nursing homes, healthcare staffing, revenue cycle management and healthcare technology. During the past 24 months, Mr. Hagood has completed over a dozen hospital transactions with an aggregate value in excess of \$1.5 billion.

# National Trends Impacting Healthcare Providers



# Hospital Systems Focusing on Three Imperatives

Navigant has now completed over 250 post-reform engagements with a wide range of physicians, payers, health systems and suppliers. Based on our experience, we believe *reform has been the catalyst for the following market forces and trends which are reshaping the healthcare landscape.*



## #1. Increased Provider Consolidation is Coming (Recapitalization)

- » Thinly capitalized and distressed hospitals & physician groups increasingly will seek partnerships, resulting in some transactions that could not have been predicted two years ago



## #2. A New Payment Model is Emerging

- » Managed care contracts, offering incentives to use accountable care tools such as more generics, less high-end imaging and ED avoidance are being embraced by primary care physicians, triggering acceptance by specialists and hospitals



## #3. Government Fiscal Pressures are Forcing Payment Cuts that Demand Provider Cost Reductions & Performance Improvement

- » Large federal and state budget deficits have exacerbated Medicare and Medicaid solvency issues, pressuring provider payment
- » The cuts are large enough to require an integrated performance improvement / strategy/ financial approach

# Value of Scale: Trend is Counterintuitive to Many

*In “New Normal” Bigger is Better for Addressing Complexity*

In the old days, “nimbleness” was doing a deal with a physician, for instance. Going forward, size makes you more nimble in preparing for future changes in care delivery and reimbursement.

**LARGER organizations are better positioned to respond to the challenges of the current landscape than smaller ones**



- Efficiencies of staff – its someone’s ‘day job’ to worry about implementing changes
- Best practice learnings from around the system
- Processes and communication systems in place that allow for rapid roll out
- Can try small scale pilots more readily
- Capital and cash to fund investments in new programs

**The result: multiple national approaches to reconfiguration/recapitalization**

# Commonly Cited Rationale for Consolidation

## How “Consolidators” Evaluate a Potential Acquisition:

- How much and how quickly will acquisition result in increased cash flow? Where will the cash flow show up?
- How difficult are the steps to achieve the cash flow? Will implementation be impeded by conditions pre-deal?
- Clinical service expansion, including the ability to provide more specialized services to the communities they serve and contribution to financial strengthening
- Better use of scarce community resources
  - Capital
  - Clinicians
- Improved care for the vulnerable and other community benefits
- Defensive motivations

## Stand-Alone Organizations Looking to Join A System Are Often Seeking:

- Mission compatibility (e.g., not-for-profit vs. for-profit, private vs. faith-based vs. governmental)
- Ensured long term viability
- Access to capital markets / capital infusion
- Generating economies of scale (cost savings)
- Support for physician recruitment and retention
- Clinical, managerial, and technological resources to reduce cost and improve quality
- Quality and cost improvement
- Defense against competitive threats
- Creative ways to maintain local control (or to maximize sale proceeds)
- Management expertise to navigate health reform

*In this round of health system consolidation, assets are not merely being “collected” ... acquirers have a clear plan to achieve strategic and financial benefits.*

# Hospital Sector Analysis



# Macro Health Trends

*"The Massachusetts Story"*

## *Is Massachusetts an indicator for the future for Healthcare Reform?*

- Massachusetts was the first state to get universal healthcare
- Resulted in accelerated consolidation and physician integration
- Hospital volume and utilization declined but overall health expenditures still rising
- Healthcare now a much greater share of state budget
- Healthcare providers face continued reimbursement pressure and need for significant costs reductions

# Macro Health Trends

## *Provider Sponsored Health Plans*

*Its déjà vu all over again*

- **Healthcare providers increasingly seeking to offer proprietary health plans**
  - Provider already bearing risk through value-based reimbursement models
  - Providers required to develop IT and administrative infrastructure for ACO programs
  - Consolidating health systems create greater opportunities for scale
  - Mechanism for addressing increased reimbursement pressure from managed care competitors
  - Provides greater flexibility in structuring physician alignment and clinical integration
  - Often a consideration when hospitals seeking an affiliation
  - What happens to group insurance with exchanges and defined contribution
- **However, Provider Sponsor Plans can result in increased enterprise risk**
  - May result in hidden capital requirements and operating distractions
  - Consolidated financial statements can obfuscate performance issues
  - Additional regulatory and litigation risks
- **But alternatives emerging...**
  - Partnerships (e.g. Aetna-Banner)
  - Private label (Evolent, Summa, Others)
  - Expansion of existing provider sponsored managed care organizations beyond sponsors service area

# Academic Medical Centers (AMCs)

*AMCs are Facing Profound Business Challenges*

## Threats to Clinical Revenues

- Medicare payment reductions - lower base payments, lower market basket adjustments, productivity adjustments – all in the ACA
- Value Based Purchasing – non payment for readmissions or HAI
- Medicaid funding reductions – state budget crisis
- Commercial payment following governmental lead
- Disproportionate Share Hospital (DSH) payment reductions
- Potential cuts if no “Doc Fix” passed annually by Congress
- Increased governmental and regulatory burden



## Threats to Medical Education Revenues

- Public university budget cuts – high, and rising – with no end in sight
- Reduced IME payments
- Limits on tuition income
- Reduced grants and contracts – both funding and wage limits
- Potential GME Reallocation
- Pension shortfalls

*Facing unprecedented cuts in research, patient care, and education, AMCs must become a hotbed of “radical new thinking”*

# Academic Medical Centers

*AMCs Must Rethink Network Strategies*

## *Five AMC Success Steps*

- Create and act like a single accountable clinical enterprise
- Embrace the "new math" of enrolled lives
- Referrals, transfers, relationships, repeat
- Improve value (cost, quality, patient experience)
- Create a role in a sustainable network (Former, Joiner, Switzerland)

# Academic Medical Centers

## *Accountable Care Organizations*

- **Most of the ~160 Medicare ACOs are located in urban areas and focus on community hospitals and/or physician groups**
  - ACOs in non-urban areas tend to focus on organized multi-specialty physician groups
- **A few notable AMC exceptions include:**
  - BJC HealthCare ACO
  - Dartmouth-Hitchcock ACO
  - Fairview Health Systems (Univ. of Minnesota)
  - Indiana University Health ACO
  - Partners Healthcare
  - University Hospitals Coordinated Care (Case Western)
  - University of Iowa Affiliated Health Providers
  - University of Michigan
  - UW Health ACO (Univ. of Wisconsin)

# Academic Medical Centers
























*AMC's are active in the national wave of consolidation*

## *Building Regional Footprints*

- **AMCs are actively acquiring/partnering with community hospitals, in pursuit of**
  - Scale economies/back office efficiencies to offset revenue erosion
  - Lower-cost delivery platforms and community networks to position for reform
  - Secured quaternary/tertiary transfers and referrals from vulnerable hospitals
  - Increased clinical revenue to support academic missions
  
- **Major recent deals include:**
  - Merger of University of Colorado Hospital and Poudre Valley Health System to form University of Colorado Health
  - Emory Healthcare formation of joint operating company with St. Joseph's of Atlanta
  - University of Maryland's acquisition of St. Joseph Medical Center (Towson)
  - Yale-New Haven Hospital acquisition of Hospital of St. Raphael
  - Temple University Health System acquisition of Fox Chase Cancer Center
  - University of Michigan Health System equity investment in MidMichigan Health
  - Trinity Health acquisition of Loyola University Medical Center

# Academic Medical Centers

*Seven models for AMC-community hospital partnerships have emerged*

Partnership Type	Select Examples
1. Acquisition by Capital Partner	   
2. Merger with Community System*	   
3. Merger with Another AMC**	  
4. Hybrid Deals (FP + NFP)***	   
5. Tertiary/Quaternary Reach	 
6. Clinical Integration/Scale	  
7. AMC Dominant Regional System	  

Examples of dissolution include: \*Health Alliance of Greater Cincinnati and Penn State-Geisinger

\*\*UCSF-Stanford \*\*\*Emory-HCA

# Rural Hospital

## *Rural Hospitals Face Multiple Challenges*

*Rural Hospital have always faced unique challenges but environment is getting worse*

### ➤ **Challenging demographic trends**

- Populations tend to be more vulnerable — older, poorer, sicker and more likely to get sick
- Rural areas general have declining commercial payer populations
- New eligibility rules will increase Medicaid enrollment by more than rural states

### ➤ **Growing shortage of healthcare professional in rural areas**

- Very difficult to replace retiring physicians
- Employment model more costly in rural areas

### ➤ **Insufficient access to capital hinders investment in technology and facilities**

- IT requirements of EMR
- Inability to upgrade with latest imaging/robotics/etc.

*Significant advantages to affiliation with larger regional network*

\*Most free-standing rural hospitals will be unable to independently meet the minimum 5,000 patient threshold for an ACO required by statute, and many will not have the staff capacity, data analytics capabilities, strong balance sheet and access to capital to manage bundled payments

# Rural Hospitals

*Rural Hospitals are highly dependent on federal programs*

*Continued uncertainty about impact of healthcare reform on federal funding programs, with shakeout of excess capacity likely*

**Critical access hospitals serve patients in the vast majority of states**



## Medicare Programs for Rural Hospitals

### **Critical Access Hospital (CAH)** N=1,325

Geographically isolated hospitals with no more than 25 inpatient beds that provide 24-hour emergency care receive cost-based reimbursement for inpatient and outpatient services

### **Sole Community Hospital (SCH)** N= 395\*

Geographically isolated hospitals are paid the greater of the current PPS rate or a base year cost per discharge updated to the current year and may receive higher DSH payments

### **Rural Referral Center (RRC)** N=125

Large rural specialty facilities with 275 or more beds may receive higher DSH payments

### **Medicare-Dependent Hospital (MDH)** N=195\*\*

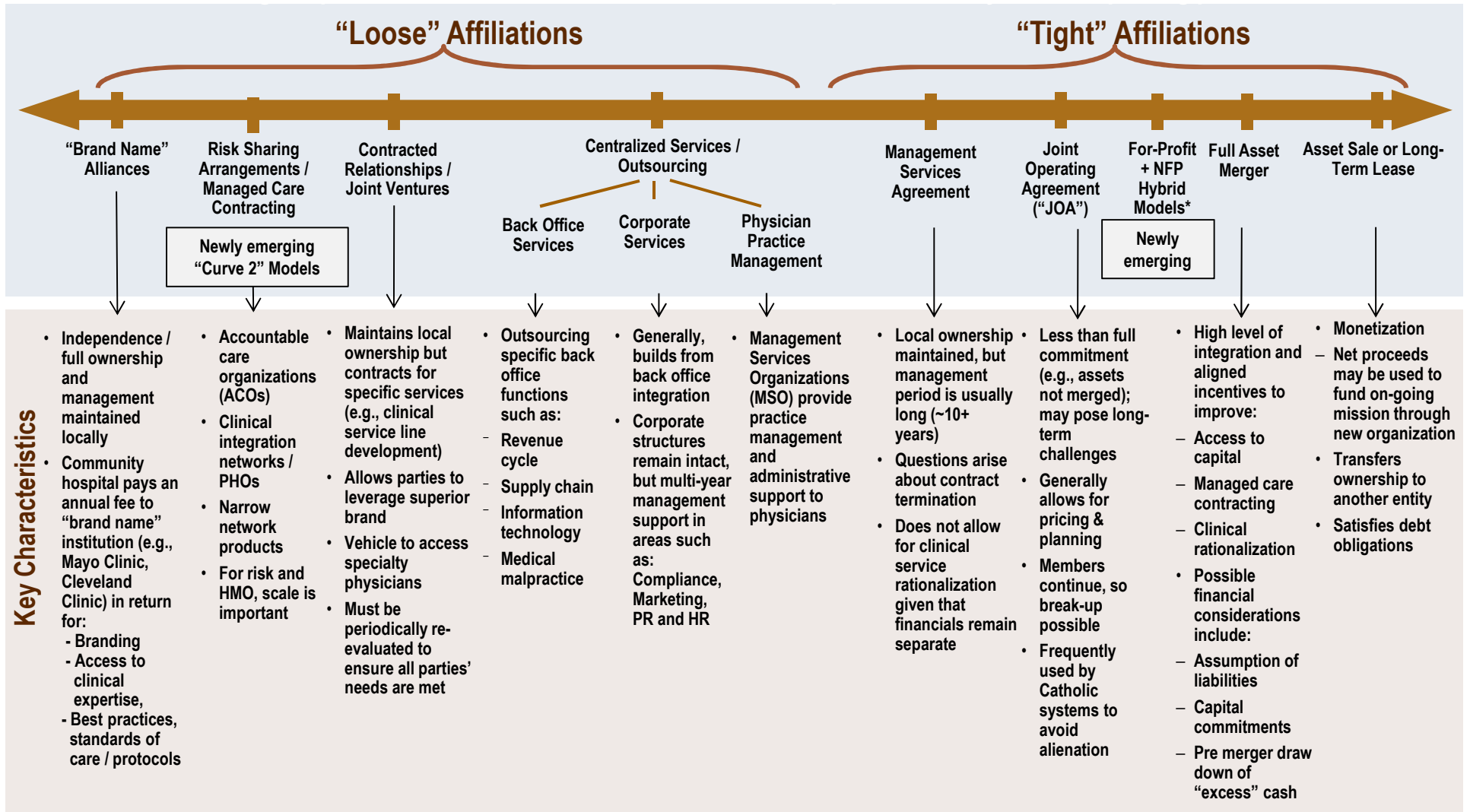
Hospitals with fewer than 100 beds and Medicare loads over 60% receive greater of PPS rate or updated base year costs

# Emerging Structures & Implications to Bondholders



# Emerging Structures

Many Collaboration Options Exist “Short of a Full Asset Merger”



\*Note: Several, large for-profit hospital operators are actively seeking opportunities to partner with not-for-profit organizations.

As such, “hybrid for-profit / not-for-profit merger models” have emerged whereby the hospital typically becomes majority-owned by a for-profit company, but the local community retains minority ownership and role in local governance.

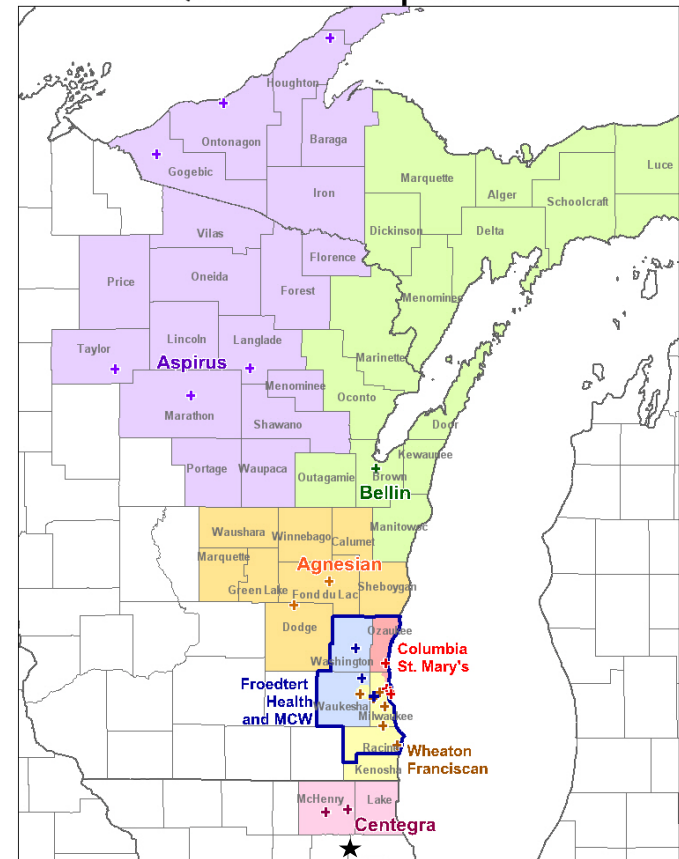
# Emerging Structures

*New Strategic Alliances Forming to Pursue Accountable Care*

- Representing 28 hospitals and 4,000 affiliated physicians across WI, MI's UP, and northern IL, Quality Health Solutions is working to collaborate to standardize quality and drive down health care costs.
- Aiming to improve the health of specific populations, QHS is launching a “narrow network” offering to self-funded employers and to commercial insurers.



**QHS Partner Hospitals**



# Emerging Structures

*What Driving Innovation?*

- Emerging structures appear to satisfy a desire to maintain independence but not at the expense of access to risk, scale or capital
- Certainly these are intended to improve cash flow, but they may not directly impact credit structure

# Credit Trends

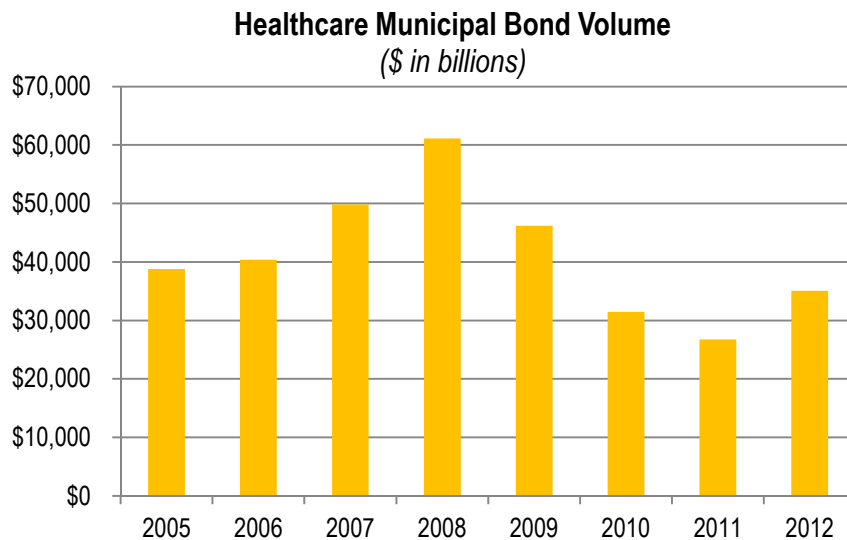


# Credit Trends

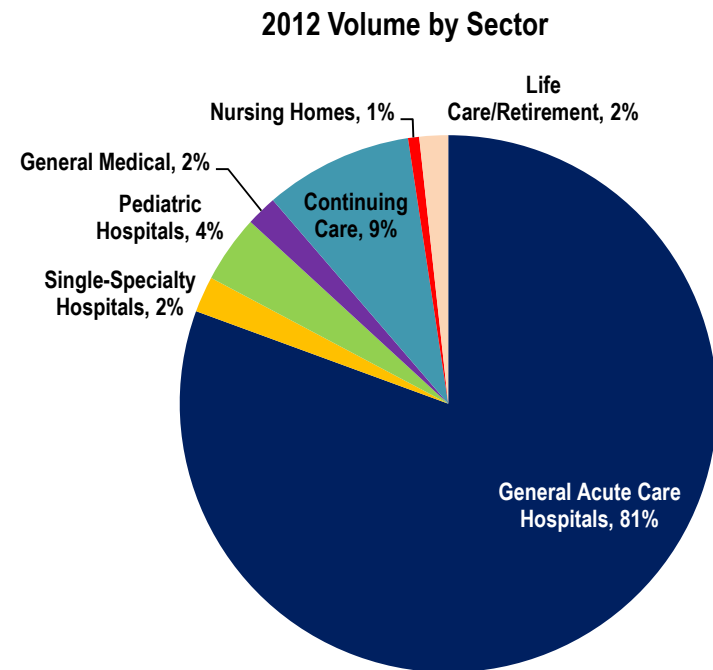
## Healthcare Municipal Bond Volume

**Healthcare municipal bond volume jumped 30.1% in 2012 from 2011 to \$35.1 billion**

- **New issuance volume approaching pre-recession levels**
  - Stable operating performance over the past two years has resulted in broad investor interest
  - Yield hungry investors less sensitive to ratings and outlook
  - Changing environment in 2013 may catch both issuers and investors by surprise



Source: Bond Buyer



# Credit Trends

## U.S. Not-For-Profit Healthcare Rating Activity

### ➤ Rating agency outlook

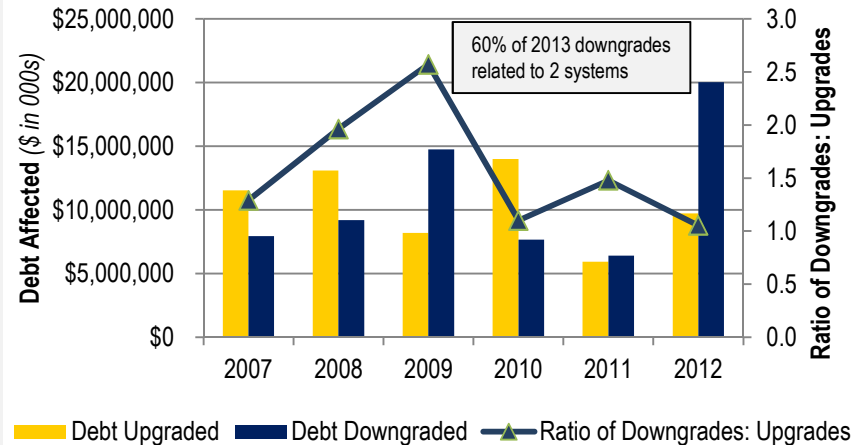
- Ratings have stabilized from 2008-2010 period
- 2013 not expected to be as favorable as 2011-2012
- Providers have succeeded in managing cost to offset soft volumes and reimbursement declines
- Many credit metrics approaching pre-recession peaks

### ➤ All providers will experience increasing rating pressures in 2013

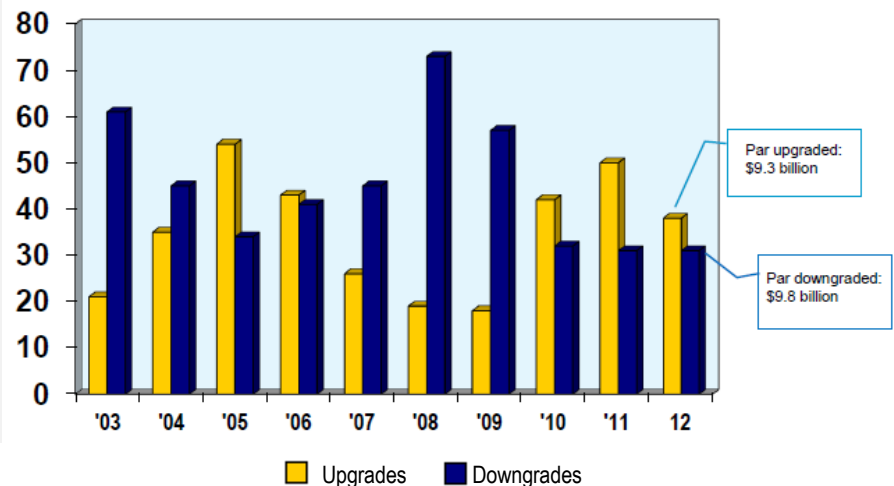
- Continued pressures from both government and private payers
- Transition to value based reimbursement
- Payor mix continues to shift toward government
- Rising employee and physician costs
- Continued high unemployment and soft economic growth

### ➤ Credit stability will depend in part on finding next level of cost savings

Moody's Healthcare Rating Trends



S&P Healthcare Rating Trends

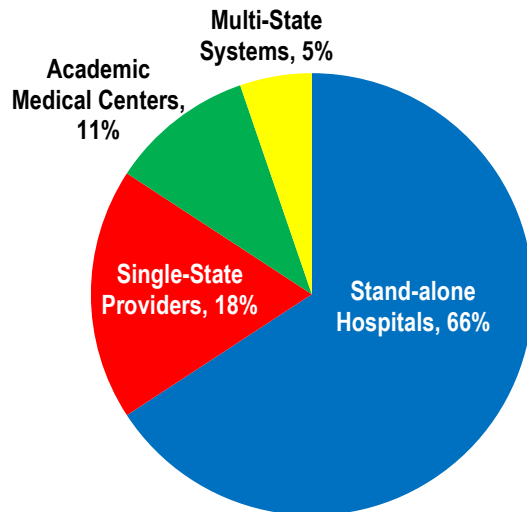


# Credit Trends

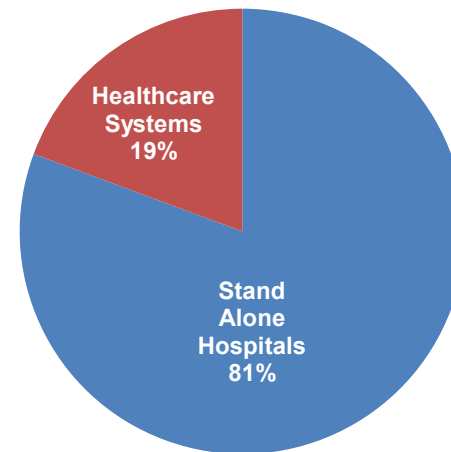
## U.S. Not-For-Profit Healthcare Rating Activity

*Downgrade activity primarily concentrated among stand-alone hospitals*

Moody's Credit Downgrades by Type



S&P Downgrades by Type



Moody's 2012 Largest Not-for-Profit Healthcare Credit Downgrades

System	Debt Affected (\$ in billions)
Catholic Health Initiatives (CO)	\$6.0
Dignity Health's (CA)	\$5.0
Memorial Sloan-Kettering Cancer Center's (NY)	\$1.9
<b>Total</b>	<b>\$12.9</b>
<b>% of Total Not-for-Profit Healthcare Downgraded Debt</b>	<b>64%</b>

# Strategic Assessment Framework



# Strategic Assessment Framework

*Key Factors which contribute to Independence...*

- Market Substitutability
- Strength of Physician Integration
- Access to Capital / Performance

# Strategic Assessment Framework

## *Identifying Ability to Remain Independent*

*The ability of a provider to remain a viable independent organization is a function of the following critical success factors:*

Factors	Descriptions
1. <b>Financial Position, Capital Access, and Ability to Make Strategic Investments</b>	<ul style="list-style-type: none"> <li>▪ Operating margins</li> <li>▪ Cost position</li> <li>▪ Balance sheet strength/debt capacity</li> <li>▪ Strong credit rating</li> </ul>
2. <b>Market Presence/Position</b>	<ul style="list-style-type: none"> <li>▪ Sufficient critical mass to be a “relevant” provider in the market in terms of: size, market share, and geographic coverage</li> </ul>
3. <b>Patient Access and Preference</b>	<ul style="list-style-type: none"> <li>▪ Access to/presence in “avenues of growth” and attractive demographics</li> <li>▪ Strong community support/positive image/preference</li> <li>▪ Limited outmigration for services available in the community</li> </ul>
4. <b>Clinical Service Complement</b>	<ul style="list-style-type: none"> <li>▪ Differentiated services and facilities</li> <li>▪ Alignment with community needs</li> </ul>
5. <b>Physician “Platform”</b>	<ul style="list-style-type: none"> <li>▪ Sufficient complement of strategically located, closely aligned PCPs with appropriate complement of specialists and sub-specialists</li> <li>▪ Ability to recruit and retain physicians</li> <li>▪ Availability of a range of alignment options for physicians from JVs to MSO to employment</li> </ul>
6. <b>Clinical Performance</b>	<ul style="list-style-type: none"> <li>▪ Quality scores</li> <li>▪ Patient and physician satisfaction</li> </ul>
7. <b>Competitive Position/Vulnerability</b>	<ul style="list-style-type: none"> <li>▪ Presence and strength of other local providers</li> <li>▪ Competitive encroachment by regional systems</li> <li>▪ Ability to recruit and retain key clinical and support staff</li> </ul>

# Strategic Assessment Framework

## *Key Considerations in Pursuing Alternatives*

*A successful Strategic Transaction requires both proper positioning and timing*

Alternative	Description
1. Determining potential strategic interest	<ul style="list-style-type: none"> <li>▪ Market demographics</li> <li>▪ Stable market share</li> <li>▪ Recent consolidation activity in market</li> <li>▪ Age and location of facility</li> <li>▪ Legacy liabilities (pension, compliance, union contracts, etc.)</li> </ul>
2. Understanding Management and Board Objectives	<ul style="list-style-type: none"> <li>▪ Understand key objectives of both Management and Board</li> <li>▪ Does Board understand strategic situation and financial position?</li> <li>▪ How does Board leadership interact with management?</li> <li>▪ What is Board composition?</li> <li>▪ Identify conflicts early – pay particular attention</li> </ul>
3. Identifying target partners	<ul style="list-style-type: none"> <li>▪ Regional presence and access to capital</li> <li>▪ Long range strategic plan</li> <li>▪ Ability to create operating efficiencies and clinical integration</li> <li>▪ Cultural fit and management style</li> <li>▪ Track record with other transactions</li> <li>▪ <b>Impact of for profit acquirers on market</b> (Two classes of for profit acquirers emerging)</li> </ul>
2. Anticipating regulatory constraints	<ul style="list-style-type: none"> <li>▪ Anti-trust considerations</li> <li>▪ Statutory restrictions on not-for-profit conversion</li> <li>▪ Faith based considerations</li> </ul>
5. Timing considerations (What is too early vs. waiting too long)	<ul style="list-style-type: none"> <li>▪ Is there realistic opportunity for material performance improvement</li> <li>▪ How stable is physician base</li> <li>▪ What other activity is occurring in market</li> </ul>

# NAVIGANT

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