

Preserving Your Community Hospital's Independence

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Introduction

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Why Not Merge?

- Speakers today will address how you position yourself for success if you don't
- But there are also reasons that it just can't be done.....
 - » Some reasons
 - Antitrust is a problem, so you cannot
 - There are cultural issues across the medical staffs
 - The transaction will be financially too dilutive
 - There is not really a plan to integrate to save costs
 - Population health won't be viable as the patient bases are not compatible
 - The Boards or management just won't work together



So What Can You Do?

- That is what we will hear from our speakers
- Today's speakers are:
 - » Steve Messinger, Principal, ECG Management Consultants, Inc.
 - » Kurt Stuenkel, President and CEO, Floyd Medical Center
 - » Ted Schwab, Partner, Oliver Wyman



Drivers of Hospital Consolidation

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Drivers of Hospital Consolidation Seeking Scale

Conventional wisdom suggests that hospitals need scale to survive and that consolidation is the best path to achieving scale.

Drivers	Description
Capital Availability →	Larger, consolidated systems have better bond ratings, better and cheaper access to capital, and they deploy more capital.
Overhead →	Merged hospitals experience significant savings on spreading fixed costs over a larger operating base. In addition, supply chain advantages from larger scale reduces non labor costs.
Risk →	Hospitals need more financial reserves to allow them to take risk based health plan contracts.
Data Analytics and PHM Infrastructure →	The data analytics and warehouse platforms coupled with expertise for population health management require substantial capital outlays.
Market Coverage →	Mergers enhance geographic reach and allow organizations to broaden their base of covered lives.

Consolidation is just one of many tactics to achieve scale.



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Drivers of Hospital Consolidation Seeking Scale

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■ Capital Availability

- » Yields among investment grade credits are compressed
- » Debt to achieve consolidation may be adverse to ratings

■ Overhead

- » 10,000 admissions threshold
- » Consolidation of clinical services drives savings
- » Group purchasing collaborative



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Drivers of Hospital Consolidation Seeking Scale (cont.)

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■ Risk

- » Adverse selection
- » Patient management

■ Data Analytics and PHM Infrastructure

- » Network arrangements/collaboratives
- » IT investments

■ Market Coverage

- » Contracting networks

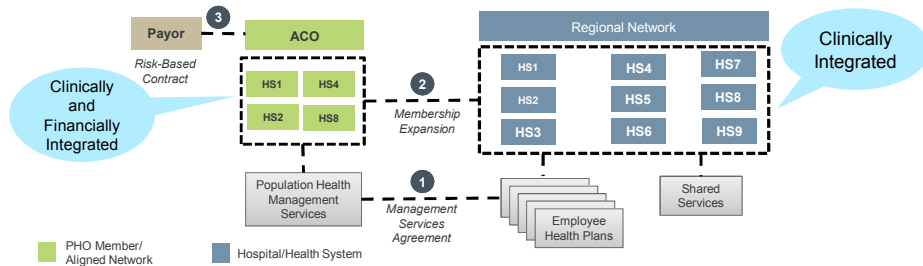
The pace of market change and long term investments required for success may favor strategies alternative to merger that are more efficient from a capital and manpower perspective.



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Clinically Integrated Network

In this arrangement, 9 independent health systems formed a network that is nesting within an existing clinically integrated network of 2 independent health systems.



- 1 **Management Services Agreement** - The ACO would lease its population health services infrastructure to the Regional Network members for the management of their employee health plans, which would leverage the ACO's existing population health management capabilities and offer the Regional Network members access to the ACO's clinical protocols and analytic tools.
- 2 **Membership Expansion** - For Regional Network providers who are interested in entering risk-based contracts in the near-term, ACO would extend membership to PHOs or other aligned physician networks that meet defined performance criteria.
- 3 **Risk-Based Contract** - ACO would serve as the risk-based contracting vehicle for ACO members, which may include Regional Network member PHOs that elect to join ACO. The arrangement does not preclude Regional Network from holding its own payor contracts.



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Floyd Medical Center

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Floyd Health System

- Mission driven
- Community-owned since 1942
- 304-bed acute care hospital
- New Polk Medical Center opening 2014
- More than 40 medical specialties
- Seven centers of medical excellence
- Behavioral Health Center
- Heyman HospiceCare
- 29 Primary Care and Urgent Care locations
- 49 Primary Care physicians
- 13 Primary Care mid-level providers
- Outpatient services



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Specialty Centers

- Bariatric Surgery Center of Excellence
- The Breast Center at Floyd
 - » Breast Imaging Center of Excellence
 - » Quality Breast Health Center of Excellence
- Inpatient Diabetes
- Joint Replacement Center
- Palliative Care
- Primary Stroke Center
- Spine Surgery Center



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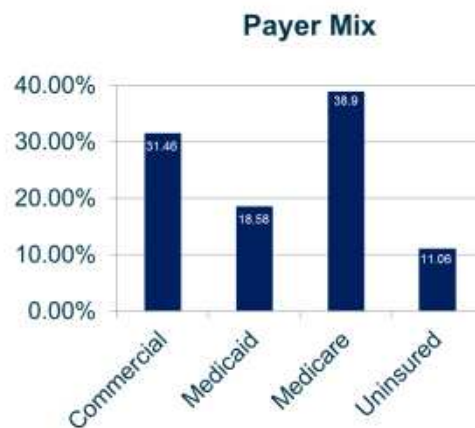
Market Share Leader

- Emergency Care
- General medicine
- General surgery
- Gastroenterology
- Gynecology
- Inpatient volume
- Neonatology
- Neoplastic surgery
- Neurology
- Neurosurgery
- Obstetrics
- Orthopedics
- Pulmonary medicine
- Urology



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Payer Mix



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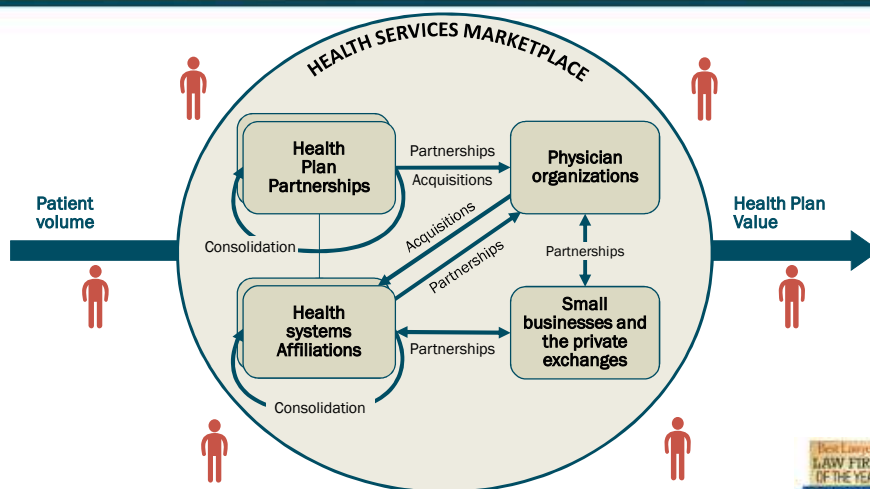
Preserving Independence and Thriving in the New Healthcare Environment

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Independent Community Hospitals Face a Choice



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To Survive In The New World, Providers Must Do Dive Things

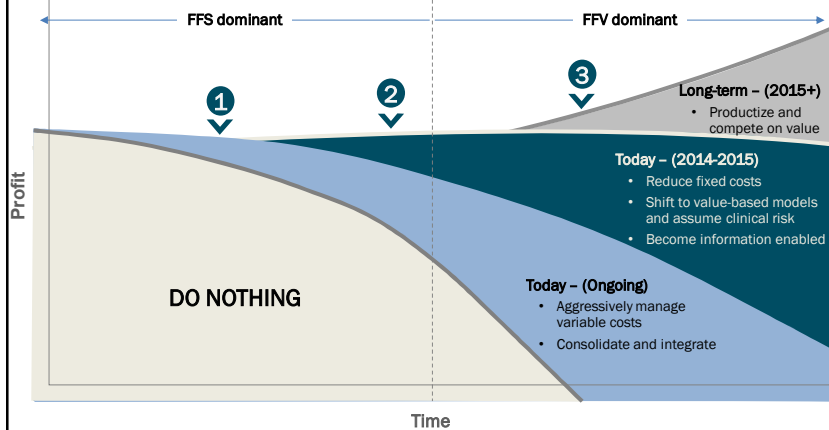
- 1 Embrace value based contracting and budgeted care
- 2 Align with physicians around networks
- 3 Create a bundled payments initiative
- 4 Explore emerging micro contracting opportunities
- 5 Innovate continuously



Community Hospitals Have A Place In Budgeted Care

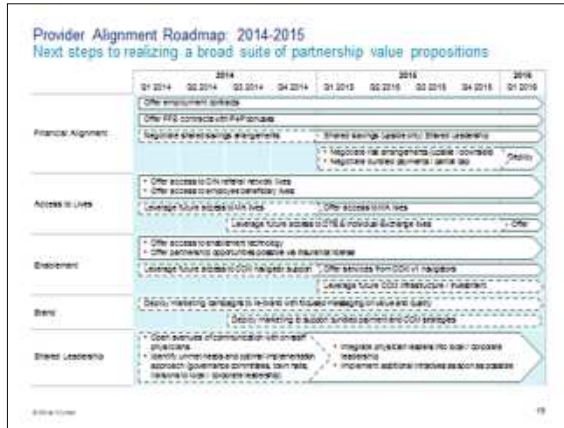
Health system options palette

By 2017 50% of U.S. health plan contracts will be in some form of risk or budgeted care



Align With Physicians Around Micro Networks

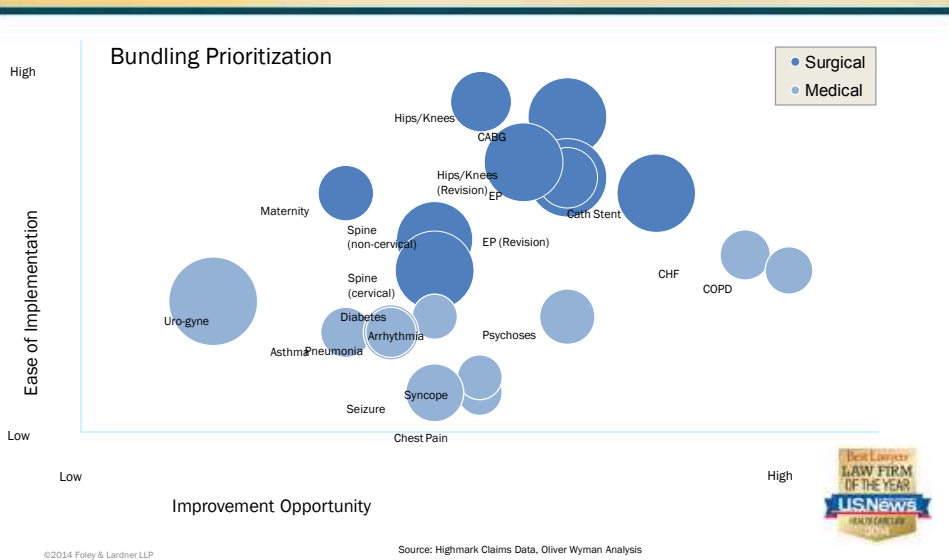
Sample Physician (Network) Alignment Plan



- In every community physicians and hospitals need to align around contracting. Payers looking for scale. Leverage, brand and enablement capabilities

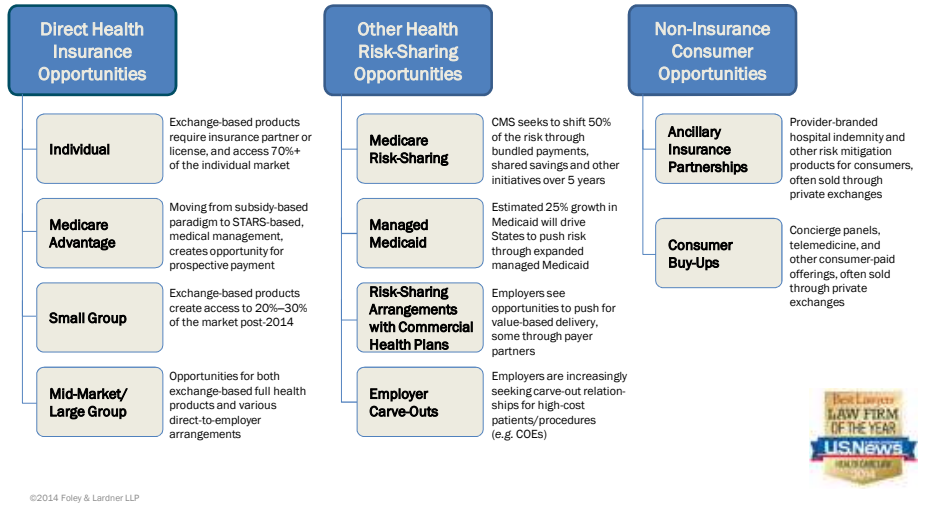


Bundled Payments Is An Initial Step Into The Game



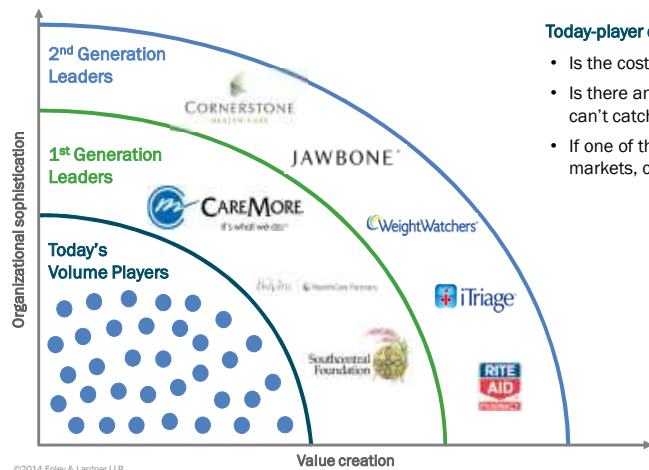
Emerging Contracting Trends

Total Commercialization Opportunity



Future Leaders Will Be Continuous Innovators

The leader advantage is expanding, fueled by new technology, capital markets, and hard-earned lessons



Today-player questions

- Is the cost of inaction on the rise?
- Is there an inflection point where we can't catch up to the leaders of the pack?
- If one of these models entered our markets, could we respond?



Conclusion

- **Survival will require working with others, and that raises legal issues**
- **Antitrust could still be problem**
 - » Narrow networks and network configuration problems
 - » St. Luke's and the vertical integration problem
- **Those arrangements with physicians must, of course, pass Stark muster**
 - » Contracts with physicians must meet the exceptions
 - PSAs
 - Lease and equipment rentals
 - Risk bearing arrangements
 - » And they must not violate the Anti-kickback statute



Conclusion (cont.)

- **And in dealing with plans, there are opportunities and risks**
- **Regulatory and fraud and abuse issues**
 - » You cannot pay plans to move business
 - » Be mindful of Medicare marketing rules in co-promotion efforts
 - » Flexibility exists in managed care arrangements such as Medicare Advantage and Medicaid managed care
- **Antitrust issues**
 - » Product co-development
 - » Network configuration clauses vs. support of narrow networks



Conclusion (cont.)

- Presenters will answer questions as time permits. Please submit your question via the Q&A box on your screen.
- A recording of today's web conference will be available on www.foley.com in 2-3 business days
- Thank you for attending
 - » Save the date for the next session in our series: Thursday, June 5.

