

Academic Medical Centers Acquiring Community Hospitals

LESSONS LEARNED

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Today's Objectives

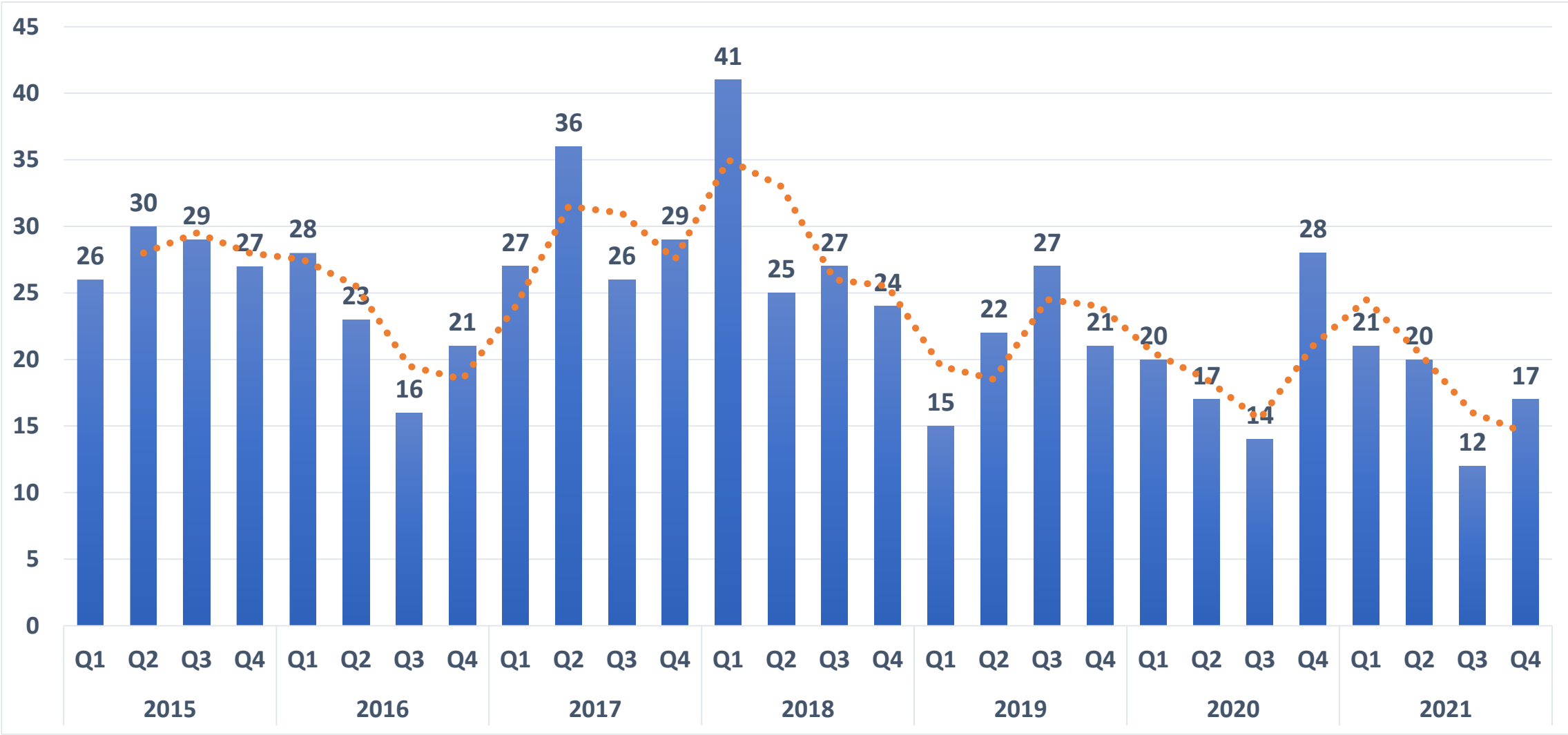
- Level set on the issues facing health systems and associated M&A trends and predictions
- Review how you might design an organizational governance model to oversee an integration
- Gain a sense of the considerations and components of integration management
- Hear firsthand some of the issues providers face after consolidation
- Walk away with some real-world lessons learned about what we may have done differently

Healthcare Environment and M&A Trends

Healthcare Landscape

- Covid-19 will continue to have an impact on operations and staff
- Pressure from legislatures, payors, and consumers to control costs and provide transparency
- Consumerism is here to stay and it is driving care delivery constructs – virtual, local, rapid, easy, etc.
- Labor constraints and burnout all across the care delivery continuum
- Pressure to deliver upon strategic plans and drive ROI
- Concept that 'bigger is better' is driving consolidation and partnerships

Change of Control Transactions 2015 - 2021



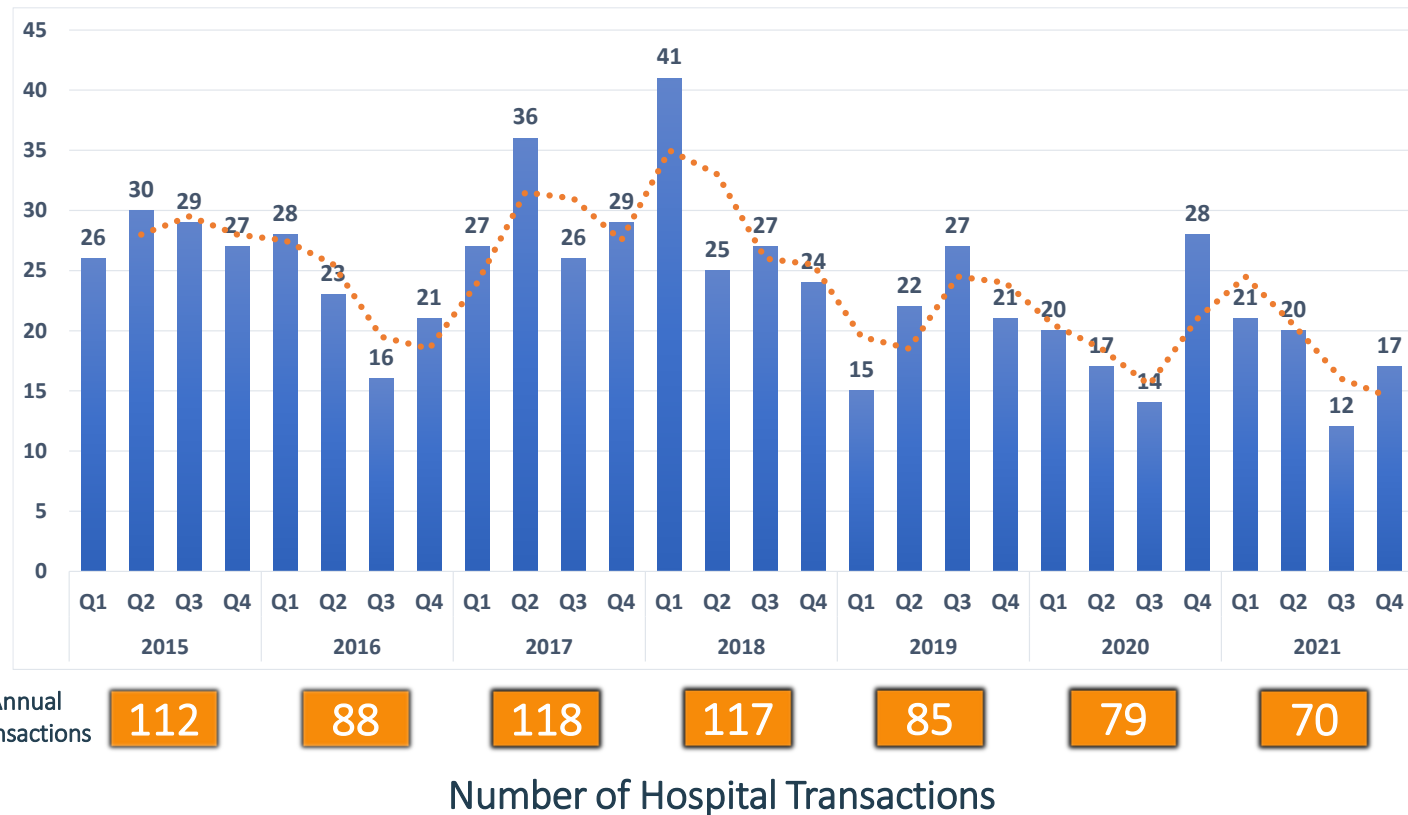
Annual
Transactions



Number of Hospital Transactions

Change of Control Transactions 2015 - 2021

Number of Change of Control Transactions



2021 Takeaways

- Transactions progressively decreasing
- Key consolidation drivers still present
- Figures exclude affiliations & JVs

2022 Predictions

- AMC activity will increase
- BODs to push realization of M&A ROI
- Community Hosp. will continue to seek partners

Case Study – MUSC Health

Case Study Framework



DEAL PRESENTATION & DUE DILLIGENCE

The deal is reviewed, performance assumptions made, and the ultimate go / no go decision is cast.



PLANNING & READINESS

Lots of work to be done – assumptions vetted, processes planned , contingencies made, and a structure put in place that can handle all of it.



INTEGRATION & OPERATIONALIZATION

Day 1 launch occurs, the integration plans begin to get tested, and now we must operate and integrate.

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Overview – MUSC Health [pre-acquisition]



86 Ambulatory Sites across
the Charleston peninsula &
greater Tri-county region

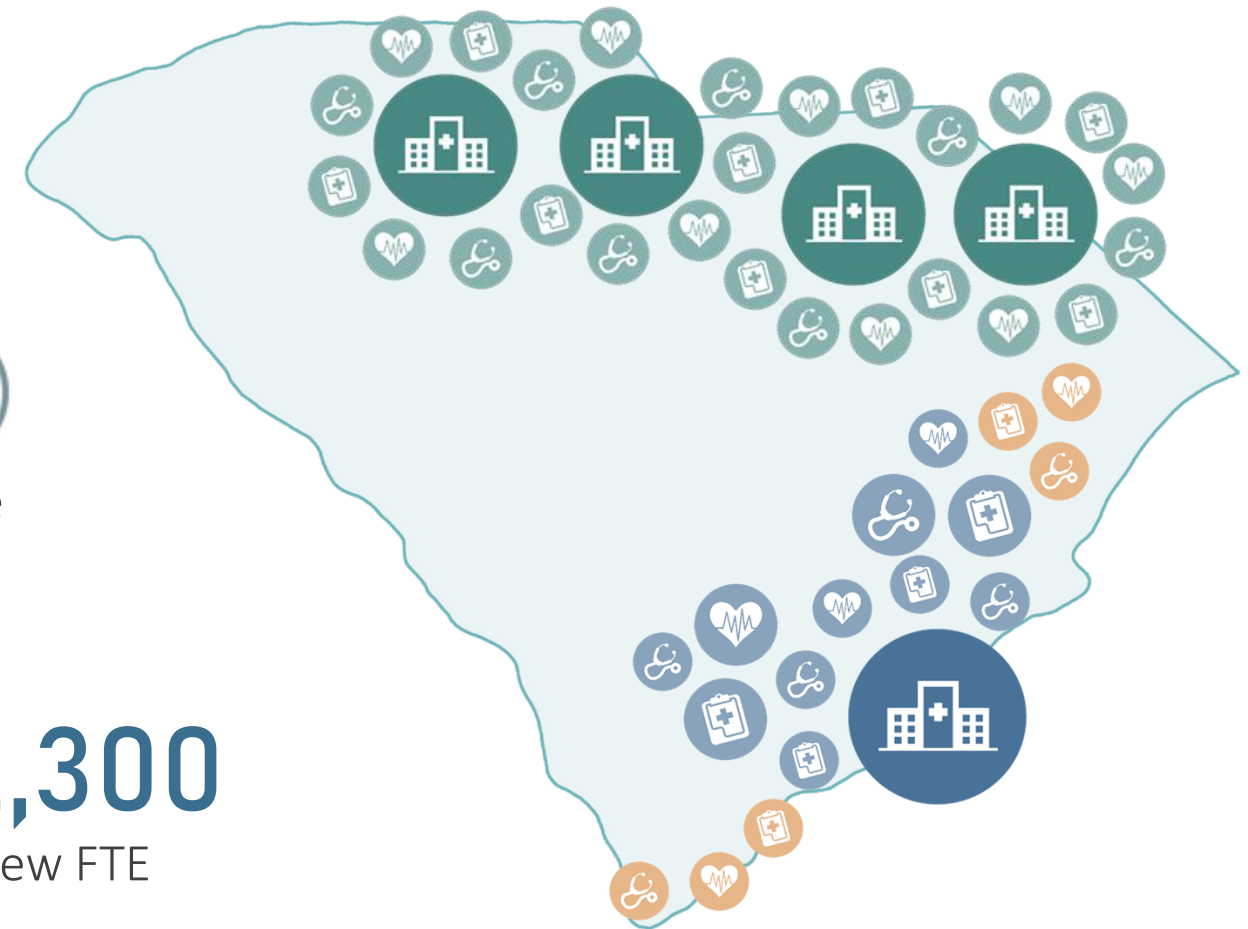
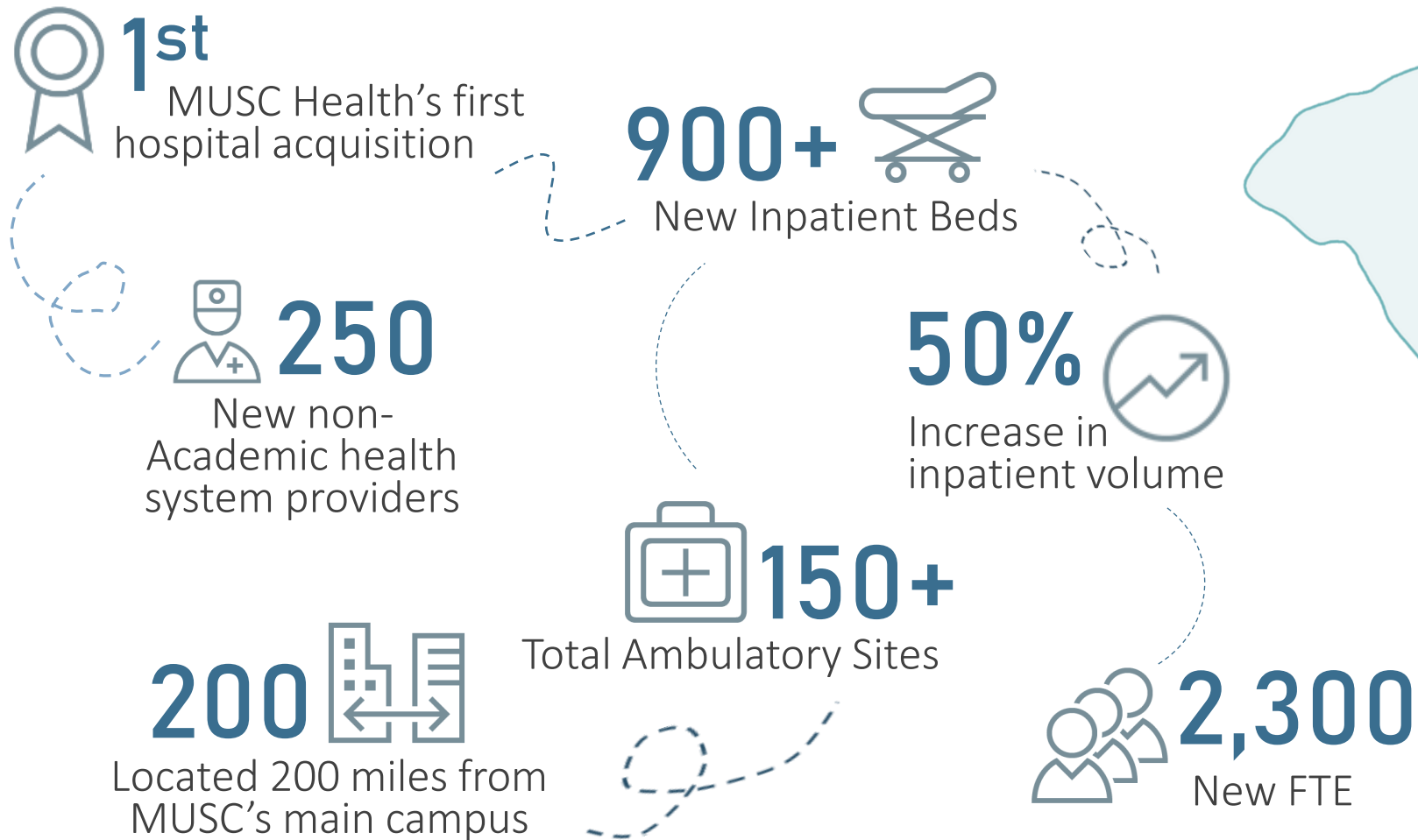
JVs & Affiliations with
4 Regional Hospitals &
Community Systems

Acute Hospital Campus
with 779 Inpatient Beds

Overview – CHS Acquisition Opportunity



MUSC Health was presented with the *opportunity to acquire 4 CHS hospitals*, nearly doubling total inpatient beds and number of ambulatory sites



Due Diligence Process



- CHS presents the confidential opportunity– only a few senior leaders are in the know
- Leadership believes it aligns with strategy and feels it is a good idea...the why

The “Why” – MUSC Health Acquisition



Finance	Presented <i>strong EBITDA margin & cash flow</i> to meet MUSC Health’s strategic financial goals
Clinical Strategy	<i>Protect and grow</i> patients from <i>outside of MUSC Health’s primary catchment area</i>
Leverage	Total covered lives, access points & footprint are key to a <i>sustainable financial plan for population health</i>
Academic Partnership	<i>Remain competitive</i> in attracting the best applicants by <i>expanding clinical sites</i> for students & GME
Community Benefit	Encourage learners to <i>stay in the local community</i> long term and <i>enhance the medical work force</i>
Physician Recruitment	<i>Control physician recruitment pipeline</i> and help with <i>physician staffing</i> via telehealth capabilities
Defense	<i>Prevent market disruption</i> of a new competitor & associated <i>impacts to financial/clinical performance</i>

Due Diligence Process [Continued]



- CHS presents the confidential opportunity– only a few senior leaders are in the know
- Leadership believes it aligns with strategy and feels it is a good idea...the why
- LOI gets executed, and due-diligence time clock starts
- Checklists are available however many are too generic or too nascent to drive the process
- Experts are engaged to help assess financials, FTC, infrastructure, etc.
- Numerous data requests are made of CHS and experts build models/scenarios
- Deadline approaches – Go or No Go.....
- Never doing this before, there is really no decision-making framework in place
- MUSC decides GO....Board of Directors executes Definitive Agreement

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INTEGRATION & OPERATIONALIZATION

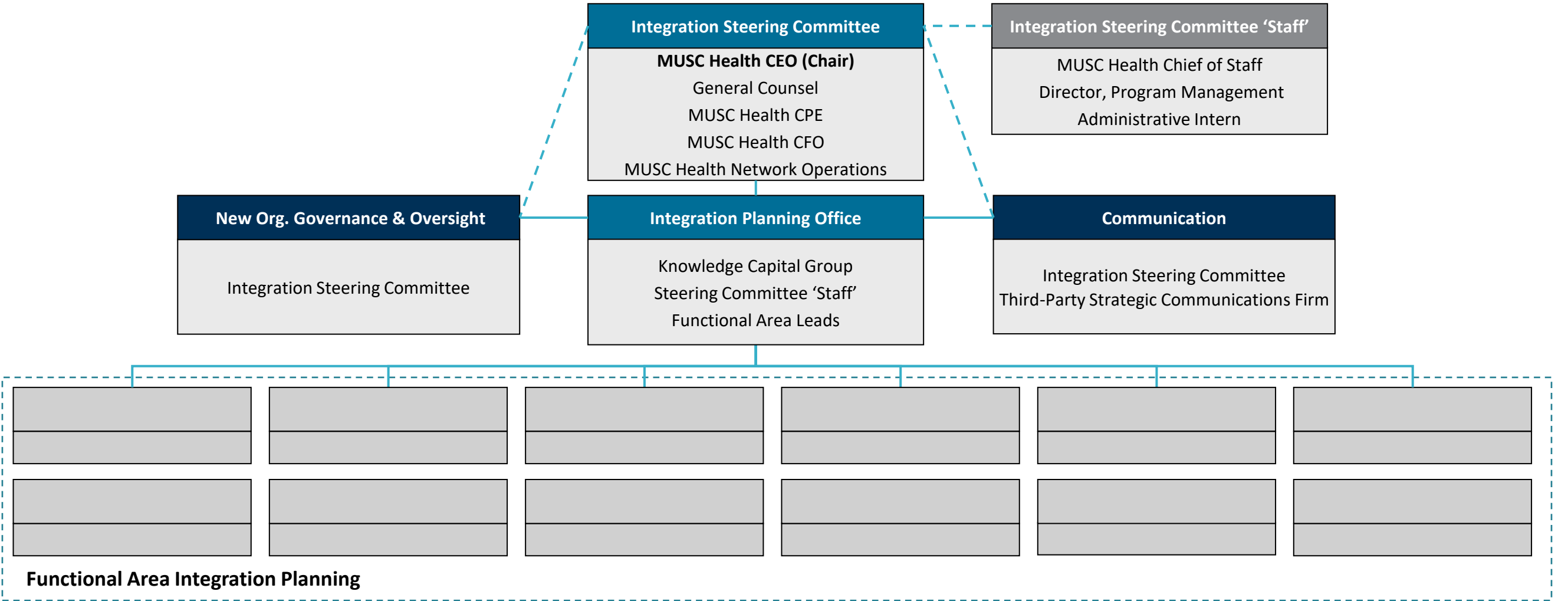
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The Integration Planning Clock Starts



- DA signed – [closing set to occur in 90 days](#)
- Must begin to engage a broader group of stakeholders – all who have questions and opinions
- Stakeholders generate an initial integration planning timeline of six months – Leadership says you have 90 days....and there are a few major holidays in the mix
- Budget models are aggressive, teams asking for more resources....assumptions proving to be 'off'
- Priority conflicts and 'noise' abounds as all internal resources are being asked to do two jobs

Project Governance

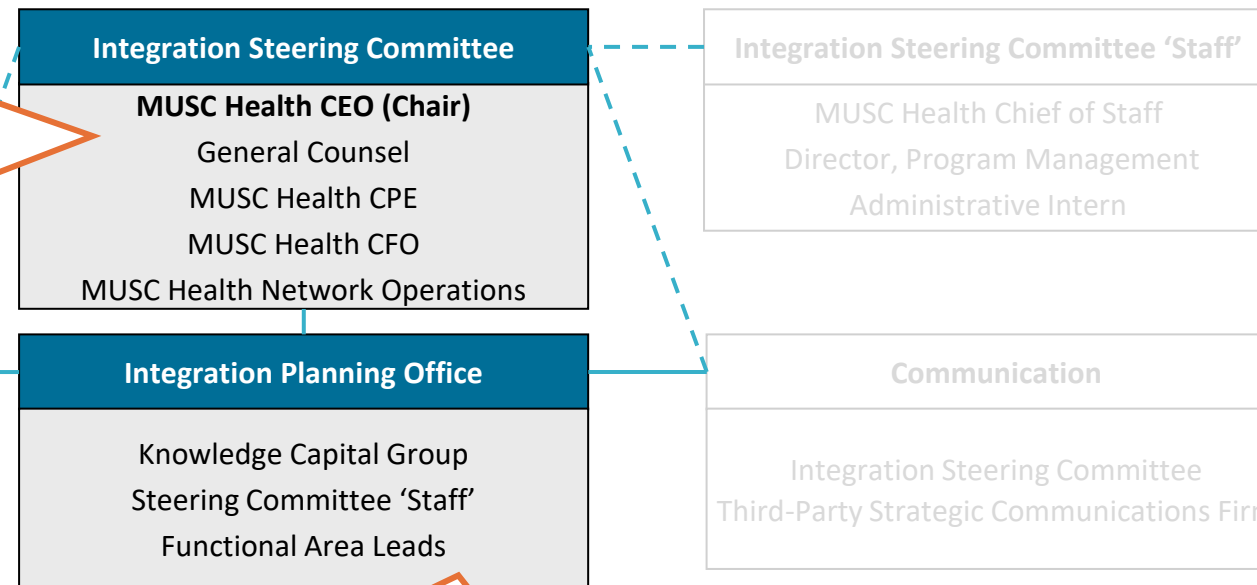


Project Governance



Role of ISC:

- Review & approve Day 1 Plans
- Review & approve budget requests
- Provide guidance in planning the transition of processes / systems
- Interaction with acquired corporate entity



Role of IPO:

- Manage and monitor Day 1 readiness
- Prep for Post-Merger Integration Activities
- Oversee transition of processes / systems
- Interaction with acquired corporate entity and ISC
- Escalate risks / issues

Functional Area Integration Planning

Functional Area Identification

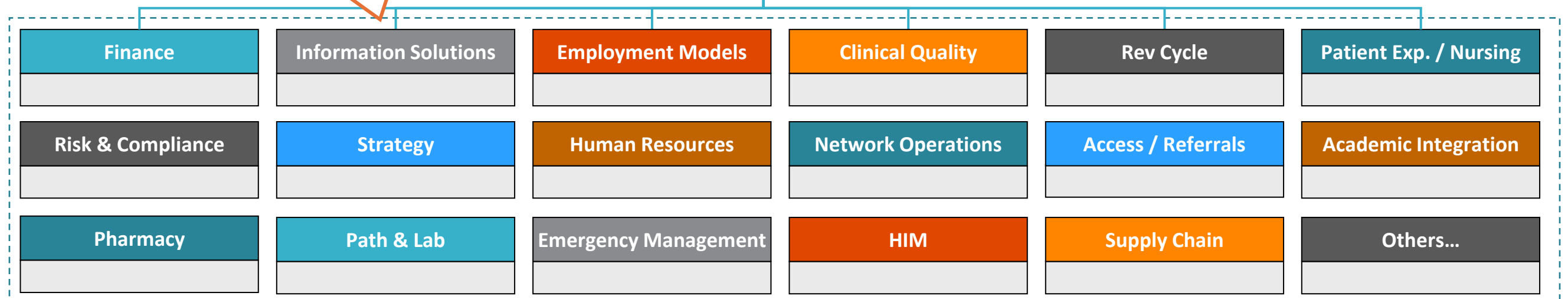


Role of Functional Areas:

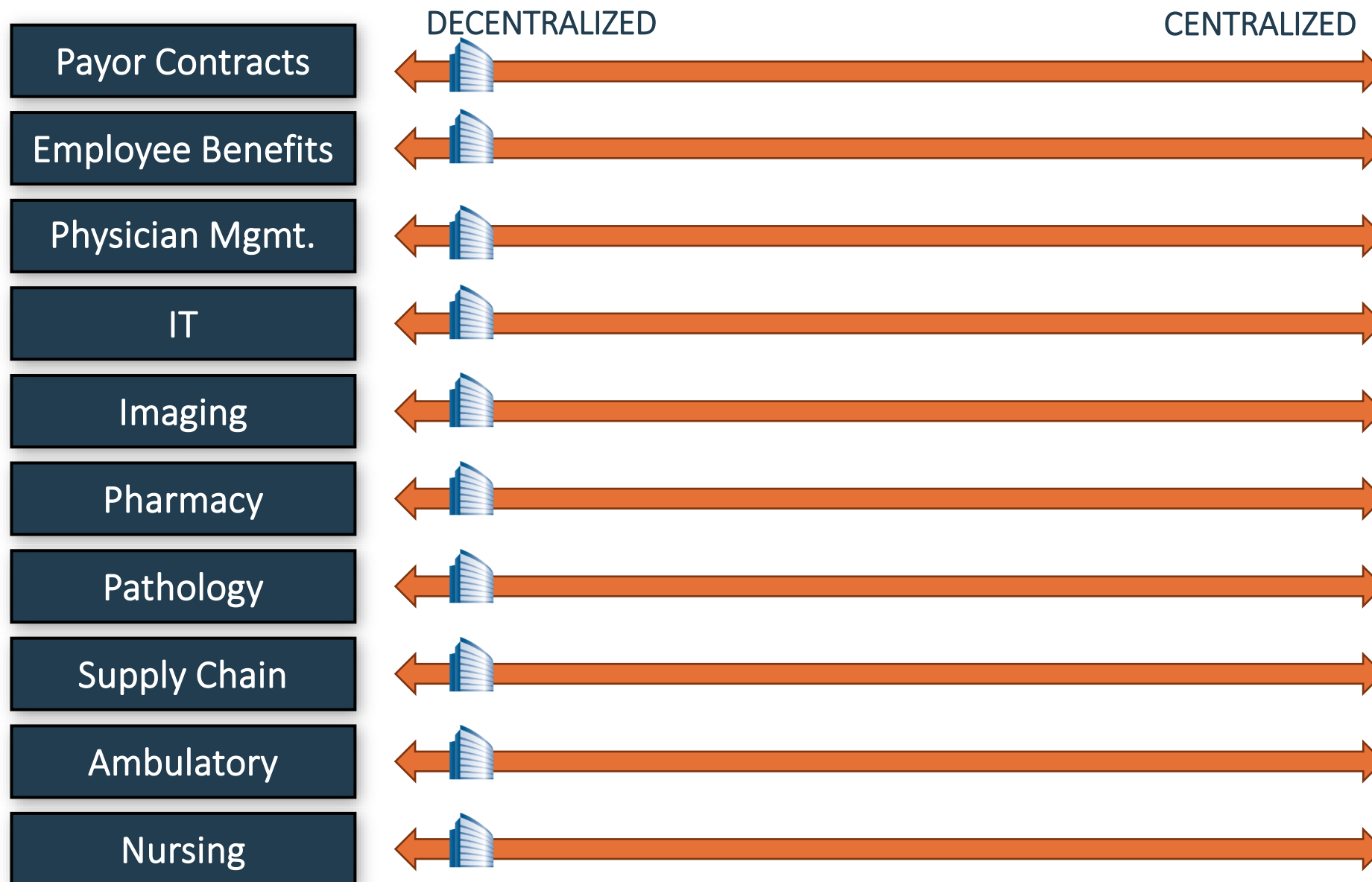
- Execute tactical logistics of Day 1 objectives
- Participate in status updates and readouts to the ISC and IMO
- Work with counterparts at acquired hospitals

Integration Steering Committee 'Staff'

Communication



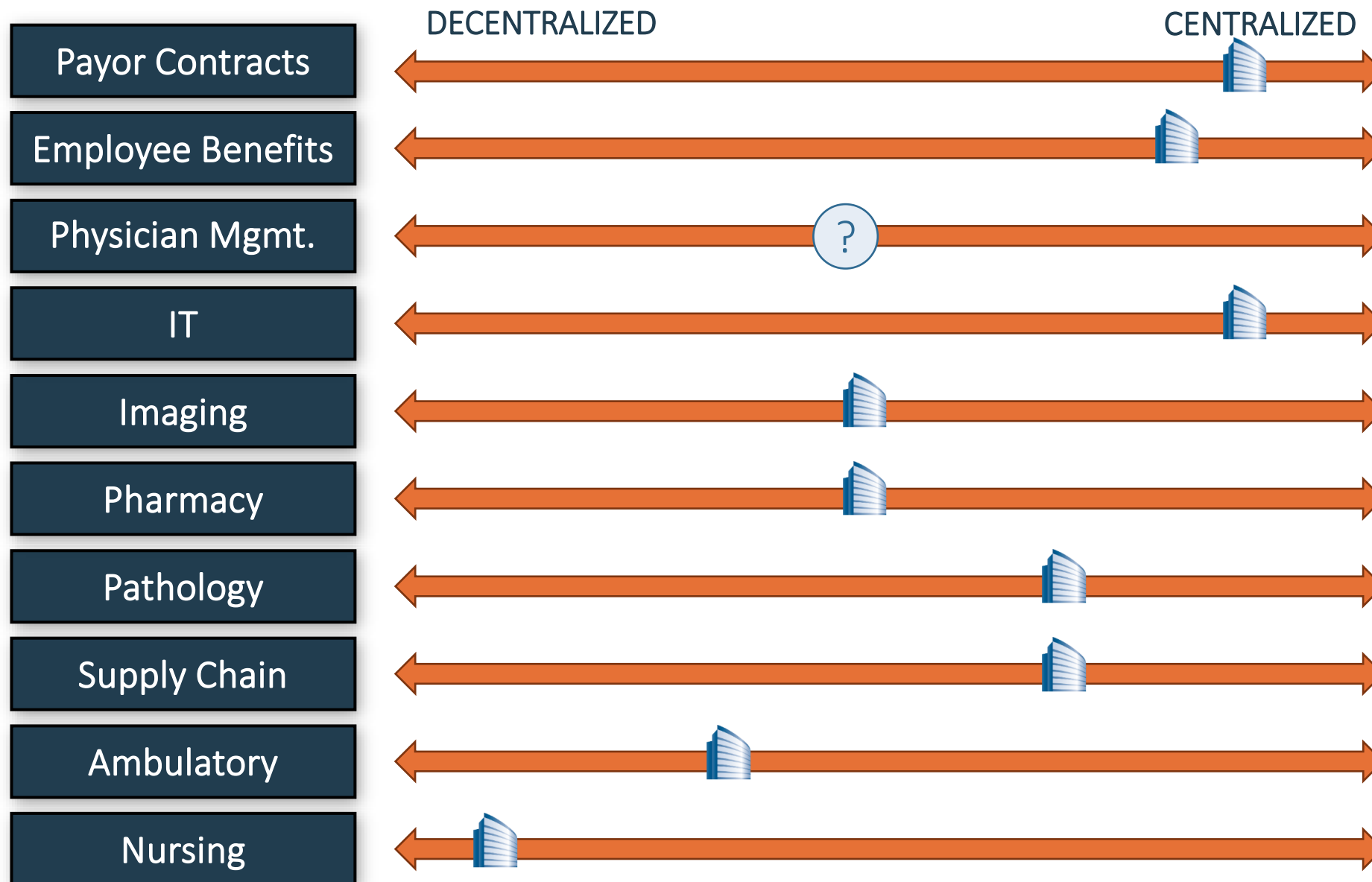
Degree of Integration



Integration Drivers

- Capacity / Capability / Leadership
- Compliance / Regulatory
- Distance / Geography
- Budget / Cost savings
- Technology Limitations
- Impact to Quality
- Timing / Resources
- Others...

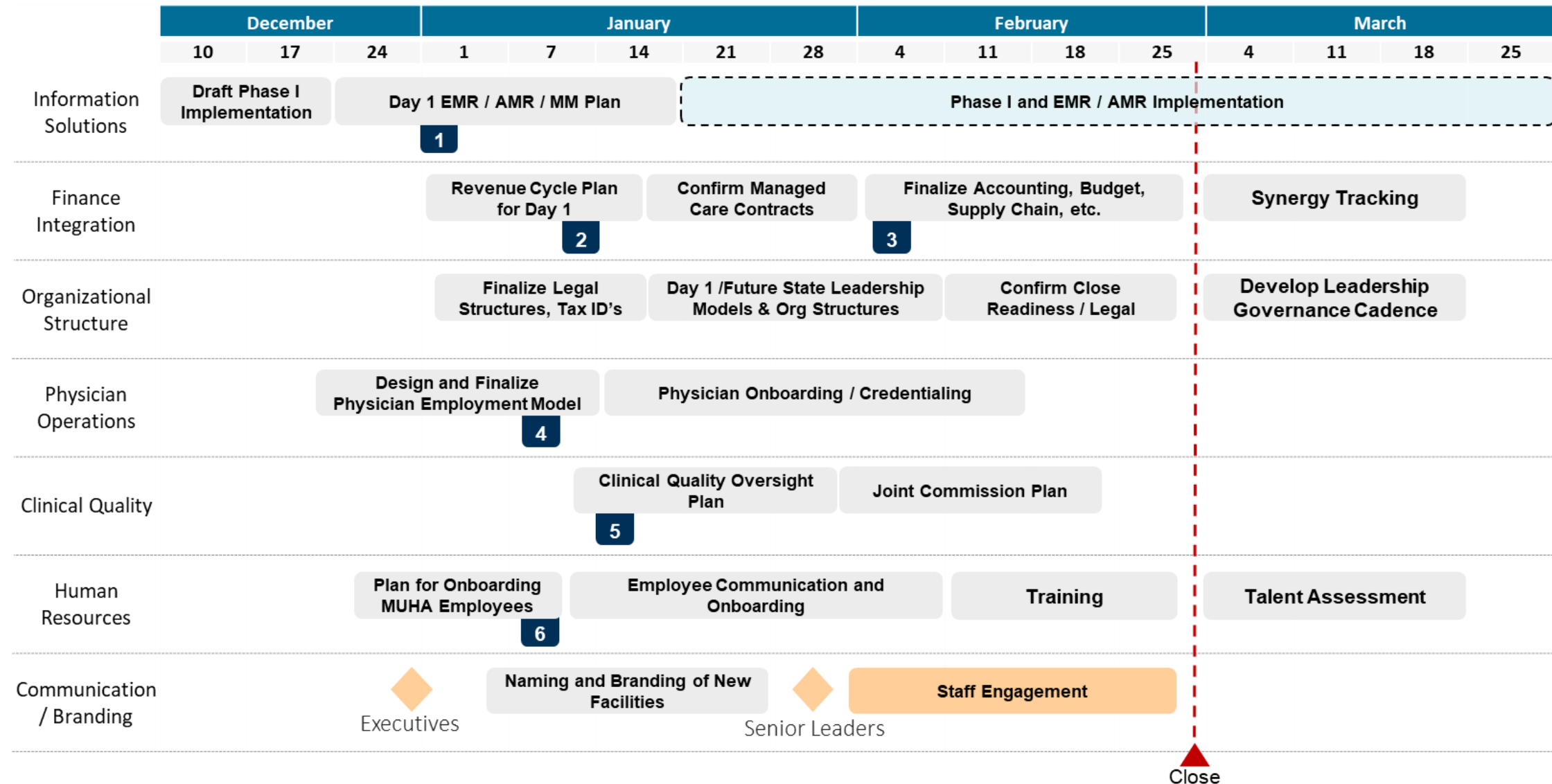
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Critical Path & Key Decisions



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Day 1 Celebrations



The Situation



- Deal is closed; operationalization has begun
- CHS utilizes a strong, central command and control....MUSC is very matrixed
- CHS had 3 EHRs, MUSC is an Epic shop
- The new providers were made part of the Faculty Practice.... part of the COM as adjunct faculty
- The hospitals are run by MUHA....but the ambulatory clinics by the Faculty Practice
- Nursing is managed at each hospital – quality is centralized
- CHS hospitals have agreements with local schools for clinical training rotations – MUSC University wants those to stop so they can send their students [RN, OA, CMA, etc]
- MUSC had non-competitive affiliate arrangements....now the newly acquired hospitals compete

Day 1 and Beyond...



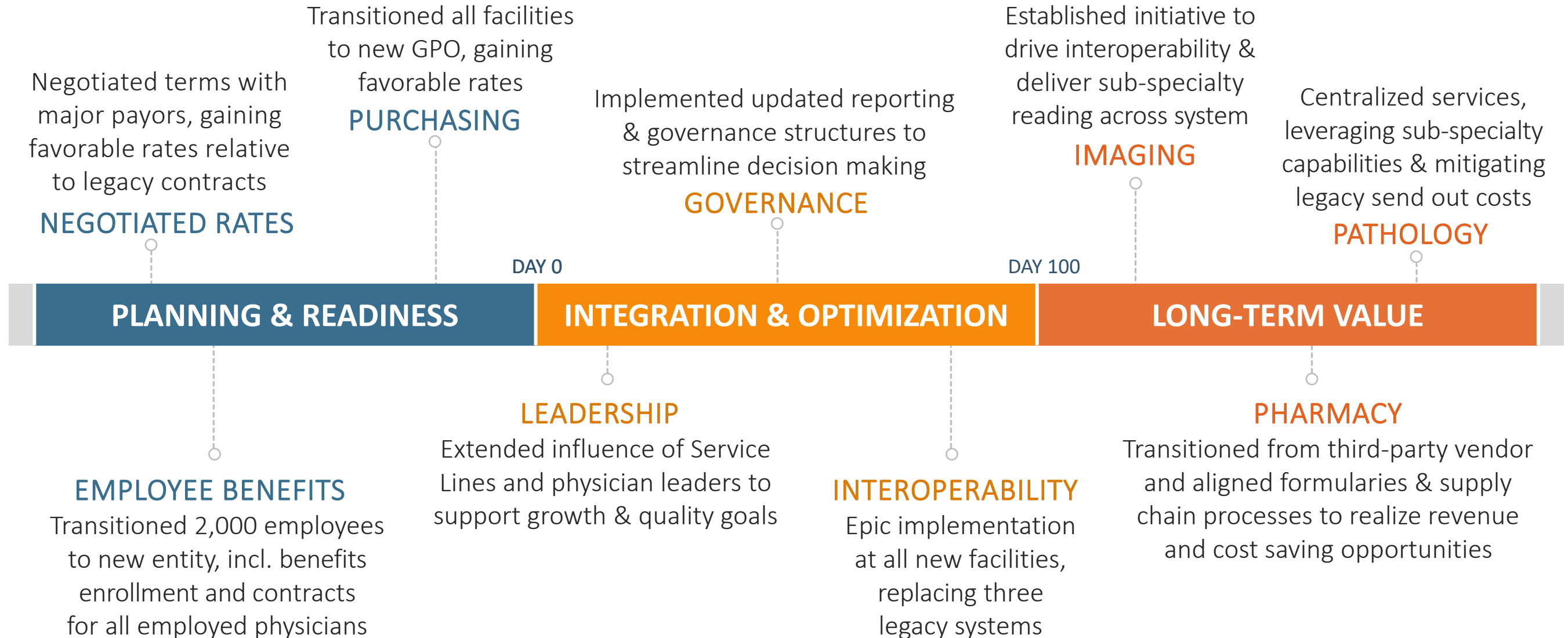
- IT – Conversion to Epic. Providers need at-the-elbow support.
- HR – Employed providers and staff need support from two different HR groups of MUSC Health
- Providers – Adjustment from prior systems to new MUSC system. Management of physician operations. Still RVU based compensation with new contracts negotiated prior to Day 1.
- Revenue cycle – Initially billing was on paper for the first 2-3 months. Difficult transition period
- Compliance – Training for all folks within first few months. MUSC Health has more compliance training requirements than previous employer.
- Hospital based operations [e.g. supply chain] have some challenges but are worked through

Considerations for Onboarding Providers



- How will the providers be employed?
- Will the providers receive academic appointments?
- Have the community providers been engaged, and what are the gaps if any in understanding and support?
- Have the academic physician leaders been engaged, and what are the gaps if any in understanding and support?
- What is the plan with the payors?

Integration 'Wins'



Closing Remarks

Lessons Learned – Due Diligence



- Have an established *opportunity pursuit criteria* to help discern if should even pursue the deal
- Create a more formal *due-diligence checklist* with more emphasis on leadership and systems
- Document the “*the why*” and have a solid talk track that is ready to cascade the message
- Get comfortable with *making assumptions*....but watch the *tendency to be too aggressive* and artificially drive deal validation
- Utilize a *formal ‘go / no go’ decision matrix* and stick to it

Lessons Learned – Planning & Readiness



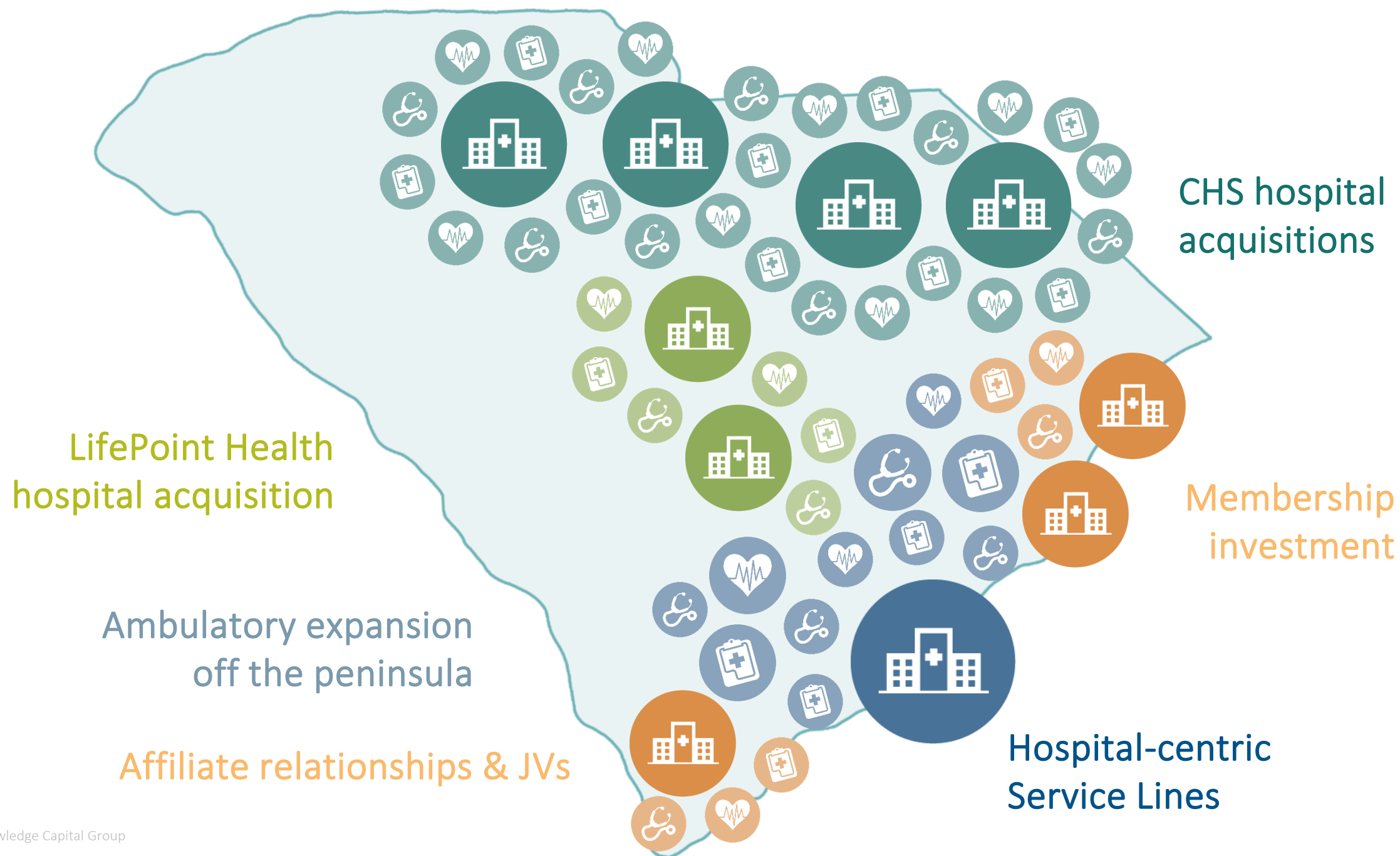
- Bring *more leaders* into the fold earlier
- Be more thoughtful about *when, how, and for what purposes* you include leaders from the ‘acquired’ entities in the *decision-making processes*
- Make sure all internal entities/stakeholders are on the same page regarding “*the why*” and *who will be on point* for things – Hospital, Practice Plan, University, Affiliates, etc.
- Realize that you *won’t* be able to make *everyone happy*
- *Appreciate the differences* in for-profit vs non-profit academic health systems

Lessons Learned – Operationalization

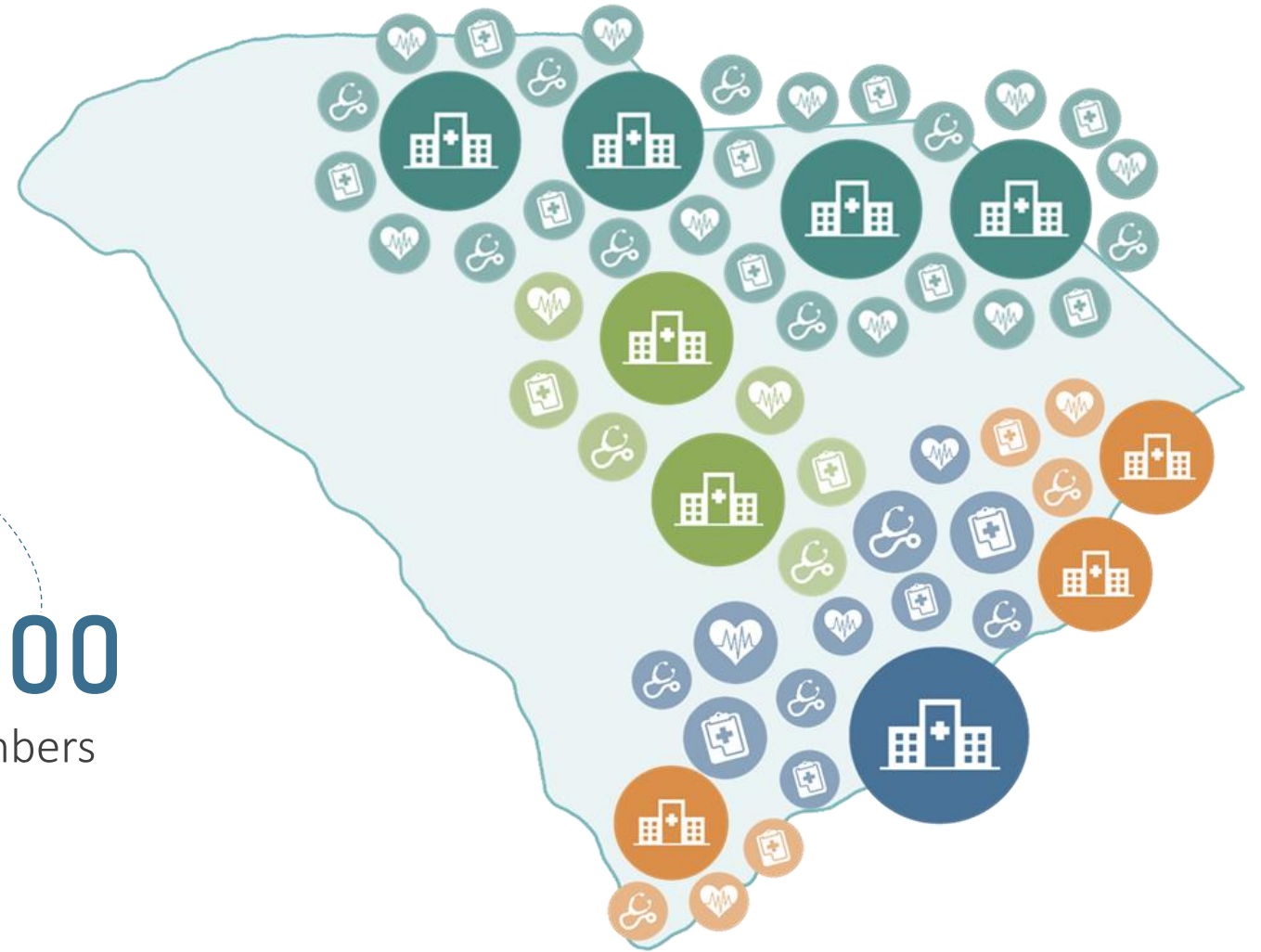
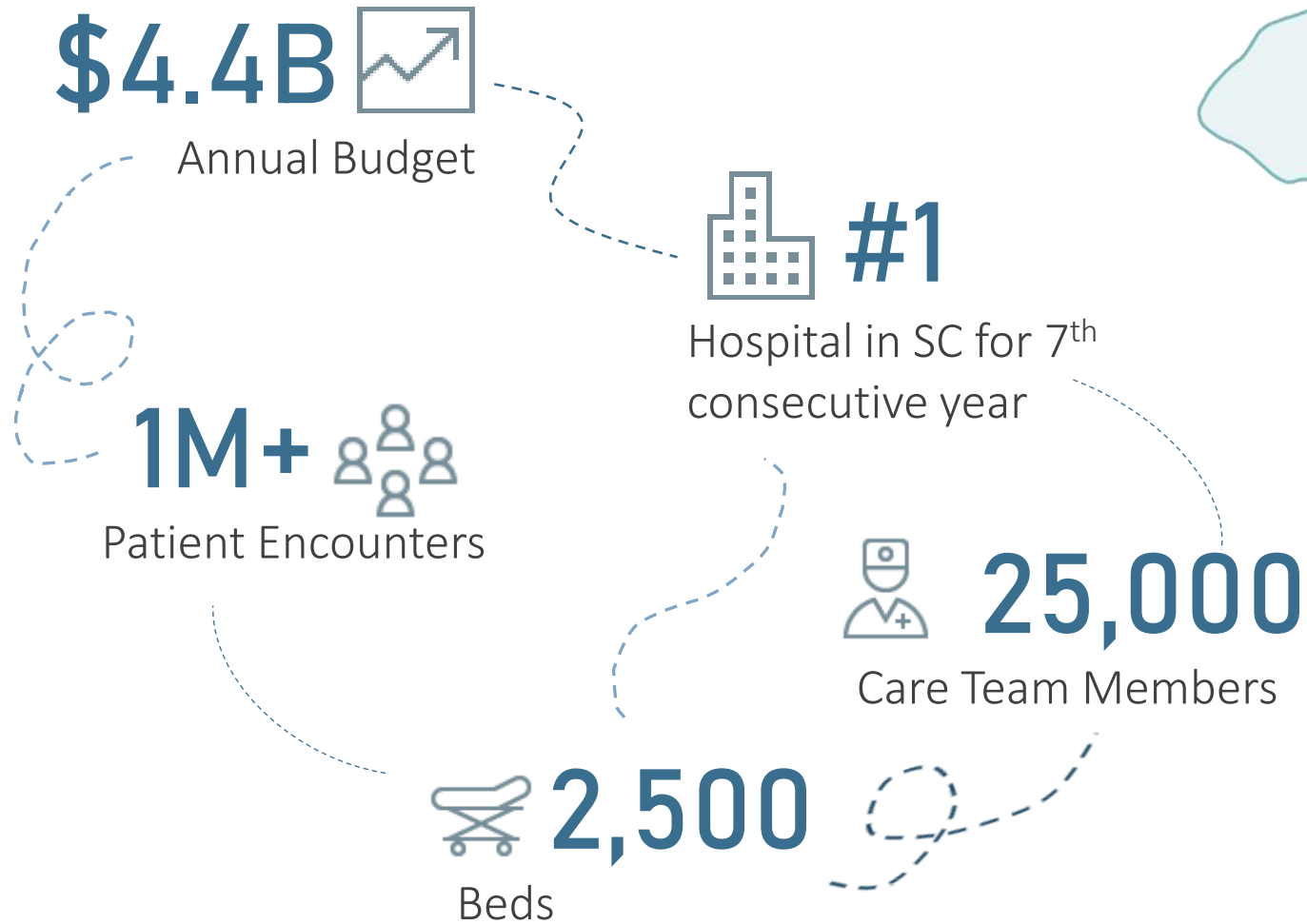


- *Start preparing* before day one, for after day one
- *Never underestimate the need for more resources*
- Keep the integration Steering Committee *going after Day 1*
- Better understand and manage how this work may impact your team – *they all have day jobs*
- *Be comfortable that mistakes are going to be made*

Epilogue – Our M&A Journey Continues



MUSC Health Today



Questions?



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