BEYOND MERGERS AND ACQUISITIONS:

When providers marry but don't live together

More than a thousand miles separate Mayo Clinic in Rochester, Minn., and Livingston HealthCare, in Livingston, Mont., and possibly as much virtual distance lies between their organizational size, structure and complexity.

The Mayo Clinic owns 70 hospitals in a handful of states, employs more than 50,000 people and has a worldwide reputation. Livingston HealthCare (LHC) has many facilities, but they are all concentrated in its small namesake city. With about 300 workers, it's the biggest employer in rural Park County.

But both Mayo and LHC demonstrate the changing business models of health care providers today that often create interdependent relationships while stopping short of acquisition or merger.

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Mayo's eTumor Board members consult with providers onscreen about an oncology case through the subscriber-based Mayo Clinic Care Network.

More than a decade ago, LHC made a decision that changed the trajectory of health care in the rural southern part of the state when it decided to partner with the Billings Clinic, now Montana's largest health care organization. In 2002, LHC "was in grave risk of going under," according to Bren Lowe, CEO of LHC for the past three years. So it entered a management contract with the Billings Clinic, which gave LHC access to group purchasing and other management expertise to help the organization survive.

Since then, the relationship with the Billings Clinic "has been more of an evolution," according to Lowe. More agreements were made between the two that gave the Billings Clinic greater say in operations and other matters—but no direct ownership—in exchange for expertise that LHC needed, including an advanced medical records systems developed by Billings, which LHC subleased "at far below the market cost" of such a system if LHC had tried to buy it on its own, Lowe said.

This relationship paid its biggest community dividend when LHC sought financing for a new facility to consolidate 15 "fragmented" offices sprinkled around town and expand the combined space. "We were facing issues," said Lowe. The hospital was 60 years old, and many services were in crammed spaces. Operating rooms were one-half to one-third the size of the norm today. "We made them work … [but] we were patching things together," said Lowe. "We could not expand services to the community without additional space."

Unable to commercially finance the cost of a proposed $43.5 million facility, LHC applied for a $40 million loan through a rural health program with the U.S. Department of Agriculture (USDA). The program had never financed a loan this large, Lowe said, and "Billings' involvement was one of the things that made it possible." The project manager, from the Billings Clinic, had experience with both large projects and small rural ones, handling all phases from planning to construction.

"That went a long way toward our approval," said Lowe, adding that the USDA "would not have been comfortable without it." This month, LHC is scheduled to move into a new 115,000-square-foot facility that is 50 percent larger than the original space.

Such arrangements are not new in health care, but they are not often talked about in the arena of health care consolidation. Yet these relationships are accomplishing many of the same objectives of a merger or acquisition.

These transactions "have a strategic driver," said Keith Anderson, a partner in the health care practice of the law firm DrinkerBiddle. Anderson has outlined a continuum of strategic transaction models that vary in the degree of integration involved between parties, from management agreements (low integration) to asset sales (high integration). The trick, said Anderson, "is to identify the driver and then dip into the tool kit to achieve the organization's objective with the least cost and administrative overhang and the best likelihood of success."

Matthew Anderson, vice president of the Minnesota Hospital Association (and no relation to Keith), agreed that there is "a wide variety of agreements" between providers today "that make it very difficult to define what level of interaction constitutes a consolidation of organizations versus a collaboration between organizations."

He pointed to Wilderness Health, a coalition of nine regional health care providers formed last year to improve quality care and patient outcomes in northern Minnesota, as an example of "achieving greater alignment and coordination of care while remaining independent," with each hospital having a director on the Wilderness board of directors.

Other arrangements, said MHA's Anderson, involve "multiple providers coming together to create a joint venture for a particular service that would otherwise be unaffordable or duplicative if each organization tried to build it independently." One example is LifeLink III, a medical air-transport company, owned and operated by a consortium of nine health care organizations. Minnesota's strong co-op culture has helped these kinds of joint ventures develop in the state's health care system, he added.

The full extent of such "consolidation lite" transactions among providers is difficult to determine. For one, they are not exactly new. Kelby Krabbenhoft, CEO of Sanford Health, believes health care has always had an "undercurrent" of different operational models. "They get people to the table" and help build trust to "then take the next step," he said. Sometimes that next step never happens; Sanford has had a management agreement with a provider in Perham, Minn., for 25 years, he said. There are also downsides to such arms-length arrangements because partners "tend to only like the good days, and you can leave the marriage," he said.

Another side of Mayo

But many sources believe these arrangements are increasing rapidly as providers react to growing reimbursement, regulatory and other pressures (see cover article).

The Mayo Clinic offers a great example of a major health care system developing an entirely new strategy toward integration with other providers that stops well short of the conventional acquisition strategy.

Over the previous two decades, Mayo Clinic "had acquired a number of hospitals throughout the Midwest" and today has a presence in 70 communities in a multistate region, according to Jeff Bolton, Mayo chief administrative officer. But in the past five years or so, he said, "we've moved away from an active M&A strategy."

While other health care systems, insurance companies and other sectors of the care industry have been getting bigger, "we didn't think that would benefit patients," said Bolton. It's not for lack of interested parties, he added. "We could have tripled our size" given the number of providers that wanted to be connected with Mayo, he said. "We felt at our current size we were at an optimal level," and additional M&A "could jeopardize the culture of the organization."

In place of major new acquisitions, Mayo decided it wanted to help health care providers offer patients "the same level of care" no matter where they were, and without patients having to travel to a Mayo facility. So it "invested heavily in knowledge"—medical research and best practices, technology, administration and other areas of expertise, according to Bolton.

The organization is now exporting that know-how as a subscription-based affiliation to providers interested in the Mayo model that do not want to give up their local independence and identity. Dubbed the Mayo Clinic Care Network, the affiliation lets providers collaborate with Mayo through channels such as "e-consults" that offer access to Mayo specialists via phone or online meetings. At eTumor board conferences, for example, affiliated doctors can describe complex cancer cases and solicit treatment advice from a multidisciplinary panel of Mayo specialists.

The new affiliation strategy started in 2011 and currently has 30 subscribers—including five in the Ninth District—spread across 20 states and Puerto Rico, and extending outside the country to Mexico and Singapore.

As with an acquisition, a lot of time goes into matchmaking, Bolton said. "There is the same due diligence [with this affiliation] as in an acquisition," he said, because Mayo wants to ensure that the two organizations "are like-minded."

—Ronald A. Wirtz