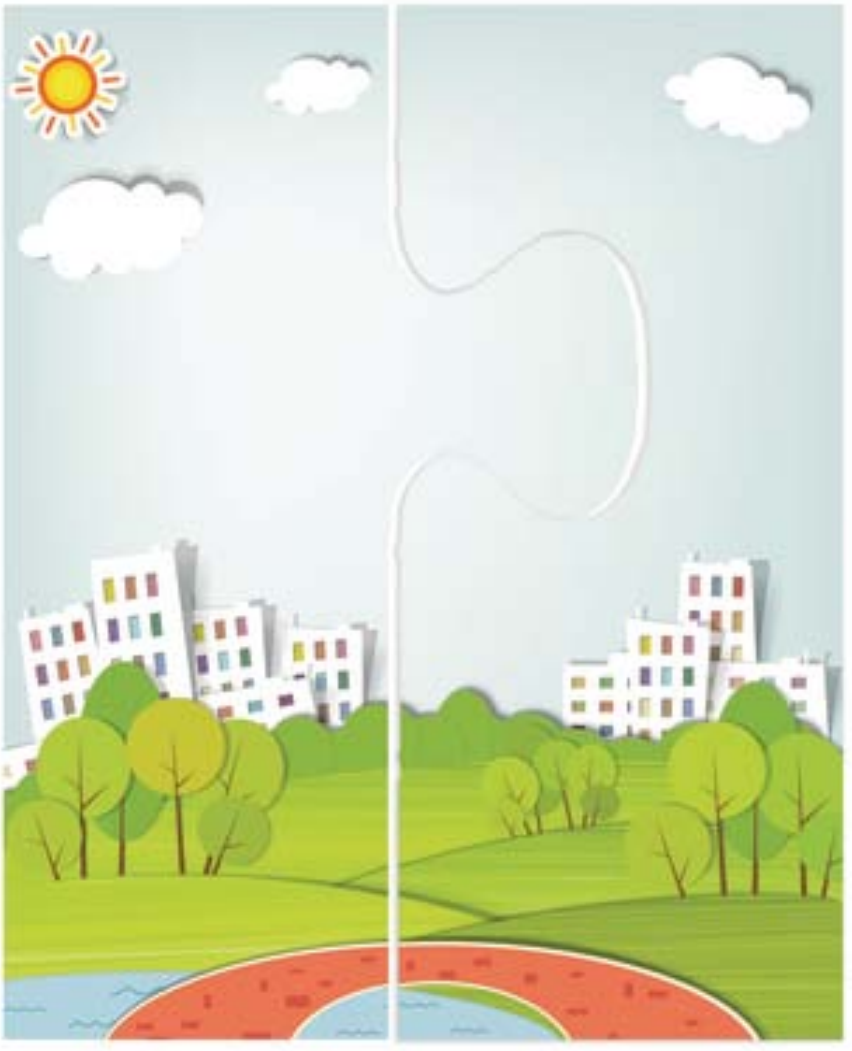
Protecting What Matters

Four considerations help boards preserve community goals during a merger

By Joseph R. Lupica



So, how many seats do we get on the board?"

Is that the most important question trustees can ask about a potential merger or affiliation? Will the answer determine how well they protected their health care institution, its mission and the community it serves?

After the meet-and-greet dinners, visioning sessions, hard-boiled negotiations and document review, how will each party achieve its objectives, and then secure what it has achieved? It turns out that trustees can seize and hold the benefits of their bargain with tools other than boardroom head count.

Boards matter. Their votes direct a hospital or health system's future, but only within the bounds of bylaws imposed by the definitive transaction agreement. Local trustees merging their institution into a system, for instance, should consider the authority a local board can — and cannot — exercise within the system. A party can grant powers to a board with one hand, while restricting those powers with the other. Generations of boards, and generations of the community members they serve, will operate under the resulting balance of power.

There are four core considerations for trustees of community hospitals or small health systems who are considering affiliation conversations with larger institutions. First, the process of achieving the desired agreement should start long before the hospital reaches the bargaining table. Second, reserved powers can trump the number of board seats the smaller entity secures. Third, hard-wired contractual commitments can trump both. And fourth, the execution of a definitive transaction agreement is only the beginning of a long-term process of monitoring and enforcing a party's compliance with its commitments.

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1. Prepare, then Pursue

The path to getting what your institution and community want from an affiliation should start before any negotiation — before you even select parties for negotiation.

Launching merger considerations with the old-school question, "Whom should we call?" does not offer trustees much conceptual traction. They instead might start with such questions as: What do we want our hospital to offer our community and region? How might an affiliation — or continued independence — get us there? When should we reach out to our constituencies for input on those questions? When should we reach out to potential partners?

These questions can define the specifications for the "Who" question and set up the high-priority topics for discussion with those parties. Considering these affiliation objectives up front helps boards and hospital leaders to avoid the dangerous game of approaching potential system partners without a clear understanding of their objectives and the value they offer. Local leaders may think they can have a harmless affiliation chat over dinner with that nice system down the street only to realize that their own hospital just appeared on the menu.

Quietly gather input. Affiliation discussions require confidentiality. At the same time, input from hospital and community stakeholders helps local leaders understand what they should seek from an affiliation and what value their hospital can bring to that affiliation. Accordingly, fiduciaries must take cautious but effective communication steps consistent with their duty to protect the confidentiality of strategic information.

The two mandates are not mutually exclusive. A hospital's normal communication efforts already should encourage community members to describe their affinity for the institution, the services or programs they value most, and the aspects of the local health care delivery system they would like to change. Carefully formed questions could quietly move the discussion toward issues related to affiliations without tipping the hospital's hand. As a simple example, the question, "What makes you proud of our hospital?" can generate responses with as much value to the board's affiliation analysis as would the forbidden question, "What does our hospital offer a potential merger partner?"

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Trustees can start by drawing in a diversity of voices:

- Families who want care delivered with both technical excellence and human compassion;
- Clinicians and staff who provide that care and depend on having a sustainable platform from which to deliver it;
- Business leaders and their employees who depend on a health care system that supports economic development;
- Underprivileged and underserved community members — voices often lost in the rarified atmosphere of a major strategy discussion — who depend on a warm welcome and dignified care from their hospital.

The resulting list of objectives can range from the philosophical to the practical, from securing your legacy and mission to securing capital for the support of key service lines. In one instance, after a public hospital considered its community's needs, it achieved long-term, post-closing covenants that would trump any agreement on board composition. In that case, the new corporate partner agreed to preserve the local hospital's maternity program and a strictly defined level of inpatient psychiatric care for 40 years, regardless of how much money those programs lost. The partner still honors those commitments some 10 years into the lease.

Other commitments might include anything from continuing a popular event that raises money for local needy families to the improvement of specific units, outpatient facilities or even the chapel.

Prepared? Make the first move. If the hospital leaders at this point have resisted the temptation to rush on to a large system's dinner plate, they can use what they have learned in these processes to approach the partner candidates of their choice. Proactively telling suitors what the community wants and what special value their hospital brings to a large system can create an early edge in negotiations. Making the first move to put their own demands on the table gives hospitals a better chance to seize control of their destiny before someone seizes it from them.

In addition, trustees must recognize that negotiations do not take place only in so-called official negotiation sessions. From the first greeting and in every conversation thereafter, your institution gains the advantage of learning about the other party's strategic objectives. Educate those leaders on how your organizational attributes help them meet those objectives. Perhaps the potential partner has just launched an initiative to expand its community network by accelerating the pace of affiliations with

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rural or community hospitals that deliver care closer to home. Perhaps it covets community hospitals that have earned the affinity of their local patient base and developed the necessary agility to offer the most effective throughput for a larger system's resources.

Every conversation with other parties is a chance to remind them that, despite the struggles your hospital may face, no suitor can just tack its sign over your door. Serving your community is a privilege that the successful suitor will have to earn.

2. Reserved Powers Trump Seats

When it's time to negotiate the newly linked organization's governance, keep in mind that having more seats at the boardroom table doesn't necessarily equal more control.

Seats on the local hospital board. The local team might negotiate a majority of seats on its local board, but the legitimate objectives of "systemness" may end up limiting the powers it can exercise. The system team can negotiate reserved powers requiring the assent of its group of directors on those decisions. Worse yet, the transaction agreement might not mention any authority for the local board and simply change its title to "Advisory Board" without any defined powers at all.

Reserved powers can work in the other direction as well. The community team can protect local prerogatives over preservation of charity care or key service lines by requiring the assent of the local group of directors on those decisions.

If the local trustees have the leverage to negotiate their own reserved powers, the contract might provide that locally appointed board members, even if in the minority, will retain sole voting power on decisions that would diminish the other party's hard-wired commitments.

As an example, the contract could grant the local members power to block reductions to key services or cuts in promised capital expenditures. And if the local leaders do not have sufficient negotiating strength to earn reserved powers, they can still exercise influence. Even a tiny minority of local eyes and ears in the boardroom can use their voice, if not a meaningful vote, to hold the system accountable to its commitments.

When local trustees are not in a position to earn majority governance authority or reserved powers to protect their minority, they may have to rely on contractual commitments alone.

Seats on a merged system board. What do merging parties gain even from earning a majority of system seats if a supermajority vote is required for every important decision? Some merger agreements delineate "classes" of directors based on the appointing party, and those documents might then grant reserved powers that require a majority of one class or the other to approve certain decisions.

Hospitals and systems have at times announced that they have entered into a "merger of equals." Even in the world of stockholder-owned companies, observers doubt whether such a merger really can exist. The question comes down to governance, not head count, which makes it more important for trustees and their attorneys to consider the voting rules of the new system board while haggling over the number of seats for each party. They should ask their attorneys how reserved powers, tiebreaker mechanics and even termination rules in the event of a final impasse might protect — or inhibit — each side.

The sad part is that two mission-driven organizations should have no sides at all after they merge. Before the trustees of the newly combined board walk into that boardroom, they should trade their team jerseys for the all-star uniform of the new organization. They should act as fiduciaries not for their home team, but for the merged entity.

3. Contract Commitments Trump All

Enlightened hospital leaders are less likely than in times past to rely solely on the charms and promises of a suitor based on good feelings alone. They now recognize that even the most well-intentioned suitor can neither predict the future nor ensure how long its own leaders will be around.

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Board members concerned about retaining local control must assure themselves that the governance details they negotiated make it into the contract, and can "stick," despite the potential impact of reserved powers. After all, board members steer the institution, define its mission and shape its culture. Think of properly empowered board seats as good software operating the hardware of the contract, for governance comes in handy when the hardware of post-closing covenants and reserved powers needs fine-tuning.

The details of the definitive agreement can turn sincere intentions into empty promises, but favorable hard-wired covenants can lock in commitments that remain immune to governance and management arrangements in most cases. When

the contract speaks in definitive terms about preservation of particular service lines, capital investment amounts and the like, even a board fully controlled by the system making those commitments must yield to those terms — if the local leaders had arranged enforcement rights and left behind an entity with standing to enforce them.

4. Hold Your Ground

Affiliating hospitals need a mechanism for post-transaction monitoring and oversight to ensure that the system abides by the contract. In an affiliation short of a total merger, the remaining local board simply may need to receive information regularly and to have a disciplined monitoring process.

In a combination that leaves no legacy entity, local leaders still can create structural enforcement by designating another local organization as a third-party beneficiary of that contract to give it standing to monitor and enforce the contract.

Alternatively, at the time of the transaction, the contract might assign local executory rights to a new or existing community trust that retains oversight and enforcement responsibilities. In that case, the contract could provide for an annual report or certification from the hospital to ensure that the system has met predetermined targets and contractual commitments for that hospital. Either way, the local leaders should consult their attorneys about these points and about negotiating provisions for liquidated damages or the remedy of specific performance.

Planning Pays Off

Look behind the debates over board composition, capital commitments and weighty legal documents, and you'll find real people who rely on their hospital's leadership to do what's best for their institution and the people it serves. Securing those benefits for the long term means going beyond a demand for board seats. It calls for careful planning and purposeful work.

Enlightened leaders will embrace the voices of their stakeholders to define objectives, will negotiate structures and commitments to achieve them, and will make sure their community can reap the benefits of the bargain they worked so hard to achieve. These leaders place their hospital in a position to retain the best parts of local control and its culture of community care, while securing the resources to advance and sustain excellence. T

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