Hospitals Consider Strategic Transactions
Surviving in the new post-health-reform environment

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The health-care industry is undergoing a seismic transformation. Four years have passed since the enactment of the Affordable Care Act (ACA or, informally, “Obamacare”), and as new health-care delivery and reimbursement models are being implemented, hospitals are being challenged to survive and thrive in this new marketplace.

Consequently, many hospitals are considering various strategic transactions to best position themselves in this new market environment. Below are four types of transactions that many hospitals are considering (or implementing), with a brief description of some major legal and regulatory issues involved.

### Mergers, Acquisitions and Affiliations

These transactions range from solo or small hospital systems combining with larger hospital systems, to hospital systems combining or affiliating into mega-hospital systems.

- **State Regulatory Approvals.** Most acquisitions involve the transfer of a license/certificate of need, which will require approval from the Department of Health (DOH). Further, if a nonprofit hospital is involved, attorney general (AG) approval will be required under New Jersey’s hospital conversion law, the Community Healthcare Assets Protection Act (CHAPA). Counsel should be cognizant at the outset of transactions involving nonprofit hospitals that the AG will be interested in the target board’s exercise of fiduciary duties, including, how they solicited proposals, considered the pros and cons of each proposal, and conducted “reverse due diligence” on the buyer, as well as any conflicts of interest.

- **Antitrust Issues.** The Hart-Scott-Rodino Act requires notification to the Federal Trade Commission of transactions exceeding certain thresholds, and prohibits “gun-jumping” (the exercise of control preclosing). Other antitrust issues may exist if the acquiror is a competitor of the target (e.g., sharing competitively sensitive information, such as pricing and physician strategies).

- **Medicare Issues.** Depending on the structure and terms of the transaction, various filings and/or approvals of Medicare may be required. For instance, in certain “change of ownership” (CHOW) transactions, the target’s Medicare Participation Agreement (MPA) will either be assigned to the acquiror, or the target will cease using its MPA post-closing because it will be covered by the acquiror’s MPA. In either scenario, both the target and the acquiror must notify Medicare of the CHOW, and there may be a period of time following the closing during which Medicare reimbursement will continue to be paid to the target until Medicare approves the CHOW and issues a final “tie-in notice.” Thus, the parties’ agreement should address the necessary Medicare approvals to be obtained, and also how reimbursement should be treated until the issuance of the tie-in notice.

- **Regulatory Diligence.** Health-care transactions pose unique regulatory risks that must be carefully considered at the due diligence stage, including, for example: improper arrangements with physicians (violations of the Stark and Anti-Kickback laws); aggressive billing tactics, such as upcoding, unbundling, and not meeting medical necessity and documentation requirements; substandard care; and HIPAA violations. If due diligence reveals significant risks, then the parties’ may negotiate provisions such as: (i) a holdback or escrow of part of the purchase price; (ii) indemnification with respect to such matters (assuming the target will have resources post-closing to satisfy liabilities); and (iii) requiring the improper conduct to be remedied preclosing, both via modified
conduct and also possibly self-disclosure and settlement with the relevant government agencies.

**Joint Ventures/Disposition of Noncore Assets**

Many hospitals continue to partner with physicians and health-care companies to invest in new and/or expanded clinical services, such as cancer care, cardiovascular services, specialized surgical services and ambulatory/urgent care centers, as well as to raise capital for information technology upgrades and cutting-edge medical technologies. Hospitals are also selling assets/services that are not essential to the hospital’s core mission (such as dialysis, ambulance, home health, imaging and real estate).

- **Due Diligence.** A joint venture is a “marriage” of sorts, and thus substantial due diligence should be conducted of potential partners, including on-site visits to other hospitals that have joint ventured with the same partner to assess their “experience,” the quality of care being provided and the overall success of the venture.

- **Structure.** A whole host of issues must be considered if physicians are also owners, so as to avoid potential noncompliance with federal and state fraud and abuse laws. Also, nonprofit hospitals must be careful to comply with governing IRS rules. For example: (i) the parties’ ownership interests, distributions and board representation should be pro-rata to their contribution of assets and capital; (ii) governance provisions should identify “major decisions” requiring a super-majority vote of the board (especially if a nonprofit hospital is a minority owner); (iii) the hospital should have the ability to initiate or veto actions so as to comply with its tax-exempt purposes (even if the hospital is a minority owner); and (iv) buy-sell provisions, such as rights of first refusal, tag-along rights and drag-along rights, should be carefully considered to protect the hospital’s interests, especially if the hospital intends to be involved in the venture long-term, and does not want it to be acquired by another entity without its consent.

- **Regulatory Approvals.** Joint ventures that involve the transfer of non-core assets and services may require DOH approval to transfer a “license” to the joint venture. Also, if the transaction involves “substantial assets” of a nonprofit hospital, CHAPA approval will be required; however, even if CHAPA does not apply, the AG’s approval may still be required under his common-law jurisdiction over the disposition of charitable assets of a nonprofit hospital.

- **Ancillary Arrangements.** Often, joint ventures will involve ancillary arrangements between the venture and one or more of its owners for certain items/services, such as billing and collections, clinical services and leases. If so, it is important that the hospital carefully consider the terms of such arrangements, including, for example: (i) requiring strict regulatory and billing compliance in providing services; (ii) mandating quality care; (iii) allowing for termination upon the breach of key terms; (iv) ensuring that the financial terms are reasonable, and subject to modification if the reimbursement landscape changes; and (v) restricting the partner from assigning the agreement to another provider that does not have similar experience, reputation and financial wherewithal.

**Physician Alignment**

Integrating physicians into hospitals has become imperative because of the emphasis on improving care coordination, quality and cost-efficiency. Alignment transactions can take many different forms, from buying physician practices and employing physicians, to leasing entire physician practices (the so-called “physician enterprise lease model”), to co-management agreements under which a hospital pays physicians to manage a particular service line (for example, cardiovascular or orthopedic services).

- **Regulatory Compliance.** Structuring these arrangements so that they comply with state and federal fraud and abuse laws is critical because they often entail complicated financial terms, including productivity-based compensation, complex bonus formulas (sometimes involving “pod” or group-based performance), as well incentive compensation tied to achieving operational and financial efficiencies (such as reducing lengths of stay or gain-sharing)—all of which pose unique regulatory issues.

- **Other Issues.** Other key issues include: (i) confirming that the arrangement is fair market value and commercially reasonable via an opinion from a reputable health-care valuation firm; (ii) negotiating the scope of noncompete provisions, including any carve-outs; and (iii) addressing the rights of the parties upon a possible “unwind” of the transaction.

**Reform-Based Arrangements**

Accountable care organizations (ACOs), including the Medicare Shared Savings Program (MSSP) and clinically integrated networks (CINs), involve the use of networks of physicians and other providers to manage the health of local populations under contracts with payors (Medicare or commercial) that reward successful outcomes through attaining quality metrics and cost savings.

- **Regulatory Compliance.** While MSSP ACOs pose reduced compliance issues because of certain government-issued fraud and abuse waivers, and antitrust
and IRS guidance, the same protections may not be afforded to other ACOs and CINs. Thus, these entities should attempt to structure their relationships consistent with such guidance, and avoid conduct such as rewarding or influencing patient referrals and implementing cost-savings measures that could have an adverse impact on patient care. Antitrust issues may also be implicated due to the collaboration of competing providers to contract with payors. Further, certain ACOs or CINs that assume risk may require registration or certification as an “organized delivery system” by the N.J. Department of Banking and Insurance.

- Contract Provisions. Some of the key issues to consider when negotiating population management contracts with payors include: (i) ensuring that payment terms are clear, such as the timing of payments, the quality metrics, and the formula for calculating “shared savings” bonuses; (ii) setting forth patient attribution methodologies; and (iii) confirming that the program does not conflict or overlap with other arrangements or underlying fee-for-service contracts.

**Conclusion**

For many hospitals, surviving in the post-reform era has entailed identifying and quickly implementing competitive strategic opportunities. This may involve a merger, affiliation or acquisition, as well as engaging in other strategies such as physician alignment transactions, ACOs and CINs. With ever-increasing pressure on hospitals to develop and implement multiple strategic arrangements, counsel for hospitals need to be both adept at identifying potential legal and regulatory issues (many of which involve “gray” areas), and also experienced in quickly recommending low-risk solutions to enable hospitals to move ahead to effectuate important business objectives.

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