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Table of Contents

Health Care Strategic Alliance Deals: The Practical Aspects

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Many hospitals are contemplating clinical and financial affiliation with other hospitals and systems through the formation of strategic alliances, rather than through traditional merger and acquisition transactions. Strategic alliances are "mutually beneficial long-term formal relationship[s] formed between two or more [hospitals] to pursue a set of agreed upon goals or to meet a critical business need while remaining independent organizations."[1] Goals of a health care strategic alliance may include: economies of scale, population health management, improvements in clinical care delivery, and increased physician engagement. Based on the individual and group goals of participating hospitals, strategic alliances vary greatly in structure. This article addresses a number of practical considerations that should guide parties to a prospective alliance in the decision to form an alliance and the ultimate outcome of negotiations.

Before making a long-term, complex commitment to an alliance, the parties should consider a number of practical business, governance, and operational issues that ultimately will shape the performance of the alliance and affect the agreements necessary to accomplish the parties' objectives. Counsel to prospective partners in an alliance should be sensitive to these considerations, and even drive discussion of them, to ensure that the parties' intent is reflected in documentation.

Shared Values, Objectives, and Outcomes

It is critical for hospital executives to flesh out these key issues early in the process of contemplating a strategic alliance. Unless the parties establish a meeting of the minds on what they want to achieve and how they will achieve it, a strategic alliance may not be successful.

Values

The parties should have a hierarchy of values that explain the rationale for an alliance. For instance, the parties need to assess if a charitable or

religious mission will be a centerpiece of the deal. Other parties may focus on serving a particular population, such as a rural community, an ethnic group, or seniors. Yet others value improving their margin (possibly as the sole means of survival) above all else. The parties need to determine if their values are consistent and, if not, whether differing values can coexist or complement one another over the long term. Put another way, the parties should decide whether upholding a particular value will trump all other purposes of the alliance.

Objectives

Hospitals should determine if they have consistent objectives with the other hospitals contemplating an alliance. Some hospitals may look to improve clinical services and clinical integration while others may be looking to improve capital access as part of a larger system. If one hospital's goal is to survive in a competitive marketplace, is that objective consistent with another hospital's goal to improve quality or to improve on value-based care? Being clear on the objectives from the outset of discussions and ensuring that all parties are working through common or consistent objectives allows parties to determine how closely to align with another hospital.

Outcomes

Each strategic alliance participant should evaluate if it will achieve its desired outcome through the alliance and determine how to measure the success of the alliance. For instance, a hospital may look at objective change in quality improvement measures, such as improved patient satisfaction ratings or improved statistics on a chronic disease such as diabetes. Other alliances may measure success through improved reimbursement for services or improved margins. The process to determine the desired outcome of the alliance as well as how to measure that outcome drives the nature of the alliance. How each hospital contributes to the outcome shapes the types of initiatives such as the desire to integrate clinical functions, e.g., pharmacy and laboratory services.

Independence and Identity

Hospitals often value a desire to remain legally independent and to preserve the identity of the institution in determining whether to participate in a strategic alliance. For instance, the hospital's identity may be integral for the sole acute hospital in a rural community that is the largest employer in that community. In such a case, preserving the historical relationship with the community will be critical to the hospital's continued success. An affiliation with a large health system may offer the prospect of improved performance and enhanced delivery capabilities from access to best practices and uniform systems across a large network. This may come at the risk of alienating key constituents due to changes in policy or procedure. Independence of the hospital may prove to be the deciding factor regarding whether to consolidate or enter an alliance.

On the other hand, the reputation of one party, such as an Academic Medical Center (AMC) or a specialized hospital, may be a more crucial factor to the success in a community where it is not presently active. An excellent reputation for quality may draw providers and patients alike to a hospital. Through close affiliation or consolidation with an AMC, a community hospital may gain a competitive advantage through tools, such as telemedicine initiatives, that could help the community hospital create a center of excellence.

Governance

At a high level, certain fundamental principles should guide structure and governance of an alliance. For example, will the parties accept a parent entity that superintends the activities of the affiliated hospitals and other providers in the network? What will be the parent entity's role—is it intended to be a centralized source of control and direction or to serve a coordinating function, facilitating cooperation among the parties and the sharing of operational best practices? In the former model, the parent exerts executive authority to direct operations at each facility, and local management is expressly subordinate to the central authority. In the latter model, the affiliated providers retain substantial control over their operations, and the parent entity provides only the sort of guidance that assures that individual providers adhere to principles that advance the purposes of the alliance, such as information and best practices sharing, cooperation on joint objectives, and the resolution of disputes. The answers to these questions in turn drive features of an alliance ranging from allocation of assets and governance to financial structures.

A critical cultural issue is the willingness of the parties, i.e., their management, to be interdependent. Generally speaking, Chief Executive Officers (CEOs) of hospitals are independent creatures who enjoy their autonomy and believe that they alone possess the vision to direct their hospital's operations. While they must have collaborative instincts to work with their boards and subordinates, the introduction of peer CEOs, who are accustomed to similar prerogatives and exercise of control, significantly changes the dynamic of an alliance. Inevitably, there will be institutional resistance to the surrender of management autonomy, which is critical to any successful alliance. This resistance can be overcome through incentives, financial or otherwise, or moderated by narrowly defining the areas in which autonomy is compromised to those on which there is broad agreement among the parties.

Another artifact of the relationship between a parent entity and individual provider constituents is the source of authority they possess. Does central authority inhere within the parent and is delegated to local management, or does the parent's authority derive from governed enterprises and remain subject to individual control in the form of reserved powers?

A common impulse in developing an alliance between historically unrelated parties is to enshrine protections for minority interests in any shared decision making. This

can include a mechanism for breaking ties in a situation where there are two parties to an alliance or more elaborate supermajority or block voting requirements on boards where there are several participating providers. In many instances, the parties may determine that certain decisions should be made outside of the alliance governing body, by what are characterized as "reserved powers."

While these types of protections may be important in achieving a level of comfort between the parties, they also can create rather cumbersome hurdles that become the enemy of effective corporate decisions and can undermine the powers of the alliance board, thereby impeding the realization of benefits from the deal. It is important that the parties understand the tradeoffs in various voting schemes and realize that what seems like a fair system to protect their interests may create a powerful veto power in the hands of an entrenched minority partner in the alliance. Before documents such as bylaws and voting agreements are drafted, it is important to sound out the leadership of the organizations and develop principles for alliance decisions that can be an important guidepost for counsel.

Asset Consolidation

Beyond the issues of governance, a key element in developing a structure for an affiliation is the consideration of revenue and assets that will be under the control of the affiliated entity. To the extent that the parties create a "strong parent" that owns or leases all of the key assets in the system and becomes either the licensed provider of care, or at the very least, the entity that controls and directs the operations, then it owns the revenue stream associated with the deal and, by proxy, the ability to incur debt to support long-term operations and capital improvements. The parent entity thus is responsible for the "bottom line" of the entire organization, and the operating subsidiaries or divisions are treated as cost centers, rather than profit centers. As noted above, there may be substantial benefits for bond and other financing depending on the relative magnitude of revenues ascribed to a parent organization.

In addition, consolidation of revenues and control of assets through a strong parent model is consistent with an integrated organization that will be treated as a single entity for *Copperweld*[2] purposes under the antitrust laws, rather than as independent prospectively competitive providers.

An alliance that results in vesting appropriate control over the joint enterprise can be accomplished through a merger of corporate enterprises, acquisition of assets of one or more providers by the survivor, or by creating a parent/subsidiary structure in which the parent entity is the sole member or shareholder of each constituent provider organization and has the power to control the board of directors and/or management of each subsidiary.

From a practical perspective, integration of assets also necessarily entails a loss of autonomy, and individual enterprises who would favor more of a confederation arrangement may resist it. In addition, maintaining accountability at the level of individual provider units, such as a hospital, physician enterprise, or sub-acute facility, may be an important discipline on local management, particularly where the parties to the alliance do not have trust earned from a period of collaboration. It is possible for a looser alliance to migrate toward a consolidated enterprise, albeit with the need for considerable care in instituting firewalls to prevent the sharing of potentially competitive information and some loss of the ability to direct and control the assets in an efficient manner. In addition, maintaining substantive separateness will impact the ability to achieve savings from combined support operations.

Efficiencies from Consolidation of Operations

Almost without exception, the two most important drivers for alliance transactions are market share (either preserving or growing it) and cost savings (through consolidation of duplicative or redundant operations)—which, of course, relate directly to revenues and margin. The challenge in structuring an alliance to achieve substantial efficiencies lies in the identification of those operations that afford the prospect for material savings. At a simplistic level, centralizing certain services, such as accounting and revenue cycle management, information systems, purchasing, pharmacy, laboratory, laundry, food service, and the like into a single enterprise may appear attractive, but a number of practical considerations require careful study before proceeding. First, and most important, determine what would be the basic platform for providing these services. In many cases, hospitals in a distinct region may rely on common suppliers for outsourced services, particularly if they have a common group purchasing organization. On the other hand, there can be wide variation in the provision of many services, ranging from whether the service is outsourced or not, whether smaller or larger vendors are used, and most important, the basic information framework in which an individual unit operates.

There will be substantial costs associated with centralization of services, including such mundane items as deciding where infrastructure will be located and the costs of moving, and also dealing with assets that will be "stranded" as a result of

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the alliance and need to be written off and disposed of. This latter consideration has a financial dimension in addition to costs. Furthermore, the negotiation of new arrangements with key vendors and the termination of existing relationships can impose both time and cost factors, which must be weighed against the projected benefits.

Most important are the issues surrounding dealing with personnel. Health systems often have very different patterns for hiring and staffing support services, and it may be difficult to assess which personnel are necessary and which are not from job classification data.

Autonomy or Tightness of the Alliance

As noted previously, loose contractual alliances, while protecting the autonomy of the individual members, can present significant legal concerns that the authors highlight to recommend that counsel be prepared to analyze for the parties and assess the relative tradeoffs between preserving individual authority and losing the certain competitive capabilities that would accrue to a more integrated organization.

Antitrust Considerations

The Sherman Act declares "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade" as illegal.[3] Not all arrangements that may have an effect on the market are illegal, but the parties need to assess whether the proposed business plan for the alliance may create unreasonable restraints on trade[4] that may arise from efforts to engage in joint pricing, division of markets, or imposition of limitations on pro-competitive activities that the parties would undertake if they were independent. If the participants in an alliance are not financially integrated and sharing certain risks associated with joint activity, they may be considered competitors in a particular market and thus capable of conspiracy to violate the antitrust laws. Addressing these concerns by limiting the scope of the parties' activities may significantly impair the ability of the alliance to deliver on key objectives.

Anti-Kickback and Self-Referral Laws

The government may characterize the entities as making referrals to each other when there is a loose affiliation. Counsel must consider federal and state regulations on kickbacks and other prohibited financial relationships. The federal Anti-Kickback Statute provides that it is a felony to knowingly and willfully solicit or receive any direct or indirect remuneration in exchange for a referral of an item or service reimbursable by a federal health care program.[5] This law has considerable breadth and requires that the government prove intent (an issue on which there is significant disagreement within the courts),[6] but a violation can be found if any one purpose for the transaction is to induce referrals.[7]

Numerous safe harbors protect certain transactions from the prohibitions of the anti-kickback laws,[8] but the parties contemplating a strategic alliance between or among health care providers need to examine whether the economies of the alliance or the sharing of revenues or expenses could be considered an inducement to refer patients among the alliance partners. More integrated organizations may be able to achieve superior financial outcomes without the same level of risk as they may more easily enjoy the benefits of a safe harbor.

Beyond the anti-kickback laws, hospitals contemplating a strategic alliance need to consider the implications under the Physician Self-Referral Law (Stark Law) in evaluating relationships between physicians and affiliated hospitals in the strategic alliance.[9] As with analysis of safe harbors under the anti-kickback laws, counsel may be able to identify exceptions within the Stark Law applicable to the proposed structure of the alliance or to advise the parties to avoid practices that would violate the Stark Law.[10]

An example of where regulatory developments may ease the burdens on alliances is found in the recent request of the Office of Inspector General of the U.S. Department of Health and Human Services for comments in developing specific regulations and standards for gainsharing arrangements.[11] The main compliance concern and prohibition with respect to gainsharing arrangements is ensuring that the parties do not directly or indirectly reduce or limit the services provided or available to patients as a result of the gainsharing arrangement. The development of new gainsharing arrangement laws hopefully will enable hospitals to implement protocols that increase quality and/or decrease cost, while allowing hospitals participating in an alliance to share in the resulting savings.

Licensure and Certificate of Need Considerations

Formal consolidation of independent hospitals may entail the creation of a new organization from the perspective of state regulators. If so, the parties need to consider whether a new entity will require licensure and accreditation for participation in governmental and private payment programs, which can entail significant delays in achieving operational objectives. In addition, in states that require certificates of need for facilities, the parties need to evaluate whether a proposed affiliation will trigger regulatory oversight under these laws or other state regulations on transfer of ownership of facilities.

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Termination

A final practical consideration for the parties is to plan for the consequences of failure of the alliance or disputes among the participants. An important feature in an alliance is a minimum commitment from each participant to remain a party to the alliance to assess the relative success of the joint effort. For instance, improvements in quality measures or economies of scale may not be apparent for three years or more and permitting withdrawal by a participant within this three-year period may defeat promising efforts to achieve all of the parties' objectives. The parties need to carefully define the circumstances under which a party may withdraw from the alliance and give consideration to an appropriate period for transition of care. In addition, if the alliance involves material consolidation of assets, the parties need to contemplate the terms of repatriation of assets as well as resolution of joint contractual obligations and financial implications such as repayment of debt.

Conclusion

While economic pressures or a need to create more physician integration to meet quality initiatives may have many providers considering consolidation, strategic alliances offer a means for hospitals to achieve some of those goals while retaining independence. Just as hospitals conduct due diligence in considering a merger or acquisition, they need to consider practical considerations in considering a strategic alliance. A strategic alliance may not realize some of the legal benefits of a single legal entity, for instance, in meeting the requirements of fraud and abuse safe harbors or exceptions. Hospitals should weigh practical business, governance, and operational strategic implications of an alliance as well as the best means to minimize legal risk and increase the economic benefit of a strategic alliance.

**The views expressed herein are solely those of the authors, and should not be attributed to any current or former employer or client. The authors may use this article, in whole or in part, in other presentations and articles.*

1 Mary Helen McSweeney-Feld, Suzanne Discenza, and George L. De Feis, *Strategic Alliances & Customer Impact: A Case Study of Community Hospitals*, Journal of Bus. and Econ. Research, Volume 8, Number 9, September 2010.

2 *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752 (1984), in which the U.S. Supreme Court held that integrated subsidiaries are incapable of entering into a conspiracy to violate the antitrust laws.

3 15 U.S.C. § 1.

4 *Standard Oil Co. of New Jersey v. United States*, 221 U.S. 1 (1910).

5 42 U.S.C. §§ 1320a-7b(b).

6 *Hanlester Network v. Shalala*, 51 F.3d 1390 (9th Cir. 1995); *United v. McClatchey*, 277 F.3d 823 (10th Cir.), cert. denied, 531 U.S. 1015, 121 S. Ct. 574.

7 *United States v. Greber*, 760 F.2d 68 (3d Cir. 1985).

8 42 C.F.R. § 1001.952.

9 42 U.S.C. § 1395nn.

10 42 C.F.R. §§ 411.355-411.357.

11 *See* www.federalregister.gov/articles/2014/10/03/2014-23182/medicare-and-state-health-care-programs-fraud-and-abuse-revisions-to-safe-harbors-under-the

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