POTENTIAL HOSPITAL MERGER & ACQUISITION MODEL

Joint Operating Agreements

Presentation for HFMA First Illinois Chapter
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Joint Operating Company

- Two or more healthcare systems create a jointly-sponsored non-profit company (the JOC) to manage the day-to-day operations of their respective subsidiary hospitals.
- The sponsors delegate significant authority to the JOC through a joint operating agreement (“JOA”) and modifications to the articles and bylaws of the managed subsidiaries.
- The commonly managed subsidiaries retain:
  - Separate identity, values and membership
  - Separate corporate existence/assets (no transfer of title)
  - Separate boards of directors
  - Neither party assumes liabilities of other (except as otherwise agreed)
- However, the model allows for significant operational and financial integration (e.g., revenue-sharing) among the managed subsidiaries
- This arrangement is sometimes termed a “virtual merger”
What are the intended benefits of a JOA

- Economics of scale and cost efficiencies for successful competition in environment of managed care and health reform
- Avoiding duplication of resources
- Offering payors unified access to quality cost effective services
- Clinical best practices
- Access to capital (depending on financial terms)
Sample Joint Operating Company

**Sponsor Approval Powers**
- Real Estate Sale > $1M
- Asset Sale > $1M
- Debt/Capital Lease > $250,000
- Admit new sponsor
- Amend articles/bylaws
- Merger, dissolution, consolidation, reorganization
- Legal actions > $2M or relating to compliance plan
- Real estate purchase
- Unbudgeted capital expenditure > $2M

Sponsor directs Excess Free Cash Flow (must be re-invested in managed companies)

**Local Board Powers**
- Credentialing, QA/UR, Licensure, Community Relations

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**Ownership Reserved Powers**

**Reserved Powers**
- Board Seats

**Proprietary Interests**

**Management Agreement and Governance Authority**

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*JOC Board representation can differ from Proprietary Interests.*
Joint Operating Company

• JOC Governance
  – JOC Board appointed by Sponsors. Representation may reflect Proprietary Interests or be 50/50.
  – The JOC’s sponsors hold reserved approval powers over the JOC.
  – In addition, each sponsor individually holds certain “ownership” type reserved powers over its respective managed subsidiaries. See sample “Sponsor Approval Powers” on chart.
Joint Operating Company

• Financial Terms
  – Each Sponsor retains a Proprietary Interest in the assets of the JOC
  – Managed subsidiaries make an annual contribution to the JOC (e.g., Sponsor’s proprietary interest multiplied by the lesser of free cash flow or a fixed minimum amount)
  – Excess free cash flow may be directed by Sponsors with set percentage required to be reinvested in managed subsidiaries per strategic plans.
Joint Operating Company

• JOA is intended to be permanent and typically includes dispute resolution provisions and penalties/disincentives for no-cause termination.

• JOC must have significant authority (like parent/subsidiary relationship) over managed companies.
  – Veto power is not sufficient
Key Legal Issues

• Tax Exemption
• Antitrust
Tax Exemption

• Integral Part Test
  – JOC will qualify for exemption as an “integral part” of another 501(c)(3) organization if:
    • It performs essential services for an exempt organization which services, if performed by the exempt organization itself, would not be an unrelated trade or business
    • The exempt organization exercises sufficient control and close supervision, based on all the facts and circumstances, to establish the equivalent of a parent subsidiary relationship
Tax Exemption

• Facts and Circumstance
  – In the context of JOAs, the IRS looks to whether a preponderance of all the facts and circumstances demonstrate that *significant control over management and financial decisions have been ceded* by participating entities to a governing body under a JOA (so as to create the equivalent of a parent subsidiary relationship).
Tax Exemption

• Facts and Circumstance
  – Factors routinely cited as “significant” in various rulings include:
    • Authority to establish budgets (including approval of major expenditures, debt, contracts, managed care agreements and capital expenditures)
    • Authority to monitor compliance with its directives and the occurrence of regular meetings of the JOC
    • Authority to direct the provision of services
    • Authority to enter into agreements which bind the participating entities, especially managed care contracts
Tax Exemption

• Failure to Establish Equivalent of Parent Subsidiary Relationship
  – If the equivalent of a parent/subsidiary relationship is not established, then adverse tax consequences may follow
  – Management of an exempt hospital by a non-exempt entity would create significant private business use issues for facilities financed with the proceeds of tax exempt bonds
Antitrust: HSR Requirements

• Hart-Scott-Rodino pre-merger notification requirements apply if:
  – JOA vests control of hospitals in the JOC
    • Authority to appoint 50% of hospital board, receive 50% of profits or assets upon dissolution
  – The arrangement meets the “size of the transaction" ($70.9M) and “size of the parties” tests ($141.8/ $14.2M)
• FTC/DOJ review the proposed transaction to determine whether it is likely to have an anticompetitive effect in any relevant market.
Antitrust: Single Entity Analysis

• If “unity of economic interest” is deemed to exist between the JOC and hospitals, then JOC and hospitals are incapable of conspiring to violate the antitrust laws.

• As a result, joint decision making on competitively sensitive matters like charges, managed care contracts, wages and exclusive contracts is immune from antitrust attack.
Antitrust: Indicia of Single Entity Status

- JOC with self-perpetuating Board not subject to sponsor approval
- JOC appoints and removes hospital boards
- JOC has authority to direct clinical service configuration
- Shared financial risk
- JOC authority over hospital financial decisions
Antitrust: Joint Venture Analysis

- In contrast to a single entity that is immune from antitrust conspiracy charges, a joint venture must demonstrate its activities are reasonably related to its legitimate, pro-competitive business objectives.

- When competing providers collectively negotiate managed care rates without clinical integration or significant financial risk sharing, they are subject to attack for a *per se* illegal antitrust violation.

- However, a financially or clinically integrated joint venture of providers may collectively negotiate managed care rates if reasonably related to legitimate, pro-competitive goals.
Antitrust: Rule of Reason Analysis

– A JOC that involves significant clinical and/or financial integration is evaluated under the “rule of reason” to determine whether, on balance, it will unreasonably restrain competition.

– The rule of reason analysis requires that any potential anticompetitive effects be outweighed by likely pro-consumer benefits.
Antitrust: Rule of Reason Analysis

- It is critical that the JOC not only put in place mechanisms that allow for clinical integration or significant risk sharing, but that the JOC in fact implement such mechanisms to drive more cost-effective care.
Polling Questions #1

• Would your organization consider a joint operating company?
  a. Yes, if it does not involve a transfer of the assets
  b. No, our M&A model is to acquire assets and operations
  c. Maybe, if we can educate our organization’s board
Example of How Hospitals and Physicians Have Integrated Entire Service Areas

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Introduction

• The following is just one example, but it illustrates the types of deals hospitals and physicians are doing

• Integration/restructuring of imaging centers
  – Conversion to provider-based or under arrangement.
  – Broader market-wide consolidation, or “roll-up,” of imaging centers for outpatient imaging.
Some Medicare Vernacular

- Physician groups (including radiology groups) and independent diagnostic testing facilities ("IDTFs") are considered to be “suppliers” by Medicare.
- Hospitals are considered to be “providers” by Medicare.
Drivers Behind Outpatient Imaging Restructurings/Integration

• DRA 2005 reduced technical component TC reimbursement for suppliers.
• Multiple procedure discounts under Medicare has also reduced reimbursement for suppliers.
• Non-governmental payor reimbursement to suppliers has followed Medicare down, either automatically (through fee provisions) or by negotiation.
Drivers Behind Outpatient Imaging Restructurings/Integration (cont’d)

• By contrast, providers very often receive reimbursement from non-governmental payors that is significantly higher than what suppliers receive.
  – Note that restructurings are not being driven by Medicare: DRA 2005 in effect equalized outpatient reimbursement for suppliers and providers.
  – Rather, it’s the advantages for providers on the nongovernmental side that’s the big driving force.

• **QUERY**: how long lived is the arbitrage opportunity?
Drivers Behind Outpatient Imaging Restructurings/Integration (cont’d)

• Everyone is looking for ways to squeeze out additional revenue and profit/margin.
• A restructuring to provider-based or under arrangement, or through a roll-up, can make this happen.
Drivers Behind Outpatient Imaging Restructurings/Integration (cont’d)

- Providers may have strategic reasons for outpatient imaging restructuring or rolling up:
  - Outreach into the community to provide a better, more expansive continuum of care.
  - Compete with other providers (e.g., moving into a competitor’s “back yard”).
  - Attract referrals from physicians.
  - Create more effective and efficient coverage and service relationships with radiology groups.
  - Develop more optimized technology investment.
  - Simply deploy available capital (some have strong balance sheets) to exploit the effects of changes in the market.
  - Build for a future under accountable care organizations.
Drivers Behind Outpatient Imaging Restructurings/Integration (cont’d)

• Suppliers may have many of the same strategic reasons.
• In addition, radiology groups are constantly looking for ways to better ally themselves, and strengthen their relationships, with their hospitals.
• Some radiology groups need to find new income sources for the group (such as coverage agreements, co-management and/or medical director agreements, and recruitment support), and these may be easier to obtain as part of a restructuring or roll-up of an imaging center.
• But in the end for some suppliers today, a restructuring or roll-up of the imaging center may present the last, best hope for the center’s survival.
Conversion to Provider-Based or Under Arrangement
Polling Questions #2

• If you operate any outpatient locations outside the “four walls” of the hospital, how are the services provided and billed?
  a. Provider based
  b. Under arrangement
  c. As a supplier under Medicare Part B
  d. Not known
Factual Scenario

• Existing hospital/radiology group imaging center joint venture, enrolled with Medicare as either an IDTF or a diagnostic radiology group practice clinic (“DRGPC”), is restructured and converted to provider-based or under arrangement.

• Variation: a hospital could buy partially into a center owned/operated by a radiology group (or other entities/persons), and then the resulting imaging center joint venture is restructured and converted.
History and Purpose of Provider-Based Rules

- The rules: 42 C.F.R. § 413.65.
- Why they were promulgated.
- They are rules of exclusion, not rules of inclusion.
- They specify the requirements that must be satisfied in order for a facility or organization to be treated as part of a main provider.
History and Purpose of Provider-Based Rules (cont’d)

• “Provider-based” is a Medicare enrollment concept, so why even worry about it if restructurings and roll-ups are being largely driven by non-governmental reimbursement?

• The answer: because it’s very difficult, if not impossible in most instances, to have a facility operate as a provider for purposes of non-governmental payors while being operated as a supplier for purposes of Medicare.
  – State licensure and certificate of need (“CON”) limitations.
  – Payor contract requirements.
  – Operational burdens.
  – IDTF performance standards limitations on “sharing” or “leasing or subleasing.” 42 C.F.R. § 410.33(g)(15).

• So if you want to be reimbursed like a provider by non-governmental payors, you’re probably going to need to find a way to be reimbursed as a provider by Medicare.
On-Campus v. Off-Campus

• There are fewer requirements to qualify as provider-based if the facility or organization is located on the campus of the potential main provider.

• “Campus means the physical area immediately adjacent to the provider’s main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual basis, by the CMS regional office, to be part of the provider’s campus.”
Provider-Based Requirements
Applicable to On-Campus AND Off-Campus Facilities or Organizations

- Licensure.
- Clinical integration.
- Financial integration.
- Public awareness.
- Fulfill specified obligations of hospital outpatient departments.
Additional Provider-Based Requirements Applicable ONLY to Off-Campus Facilities or Organizations

• Operation under the ownership and control of the main provider.

• Administration and supervision.

• Location
  – Generally no more than 35 miles from the main provider and in same state or adjacent state when consistent with the laws of both states.
  – Other, narrow ways to satisfy location requirement.
Provider-Based Status for Joint Ventured Imaging Centers

• The joint ventured facility or organization must:
  – Be partially owned by at least one provider,
  – Be located on the main campus of a provider who is a partial owner,
  – Be provider-based to that one provider whose campus on which the facility or organization is located, and
  – Meet all requirements that are applicable to BOTH on-campus and off-campus facilities and organizations.

• As a result, off-campus joint ventured imaging centers *per se* cannot qualify under the provider-based rules.
What If a Joint Ventured Imaging Center Will Be Involved?

• If on-campus, then may be able to qualify under the provider-based rules.
• If off-campus, cannot qualify under the provider-based rules.
• An alternative for off-campus, joint-ventured facilities or organizations may be the under arrangement rule.
Under Arrangement

- The statutes: 42 U.S.C. §§ 1395x(s)(2)(C) and (w)(1).
- The rules: 42 C.F.R. §§ 409.3, 410.27(a), 410.28 and 482.12(e).
Under Arrangement (cont’d)

- Receipt of payment by the billing provider (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment made by Medicare must discharge the liability of such individual or any other person to pay for the services.
Under Arrangement (cont’d)

• The billing provider must exercise professional responsibility for the services obtained under arrangements:
  – Apply same quality controls over under arrangements personnel.
  – Apply its standard admission policies.
  – Maintain a complete and timely clinical patient record.
  – Maintain liaison with under arrangement entity’s attending physician.
  – Ensure that medical necessity is reviewed on a sample basis.
Provider-Based v. Under Arrangement

• Be aware that:
  – Any facility or organization that furnishes ALL services under arrangements cannot qualify as provider-based.
  – Providers cannot contract out entire departments under arrangements while claiming them as provider-based.
Provider-Based v. Under Arrangement (cont’d)

• But the big distinction is . . .
  – Provider-based facilities or organizations are not required to satisfy the under arrangement requirements, on the other hand . . .
  – CMS has given mixed signals on whether facilities from which services are obtained under arrangements must satisfy the provider-based requirements.

• At a minimum, CMS likely will look at the nexus between the hospital and the entity operating the imaging center.
Provider-Based v. Under Arrangement: The Choice

- If on-campus, restructure as provider-based.
  - Owners of imaging center joint venture will need to understand fully and make sure that they are comfortable with the provider-based requirements.

- If off-campus, restructure as under arrangements.
  - Again, the owners should fully understand and be comfortable with the (less burdensome) under arrangement requirements.
Supervision of Hospital (Provider) Outpatient Diagnostic Services

• The rules: 42 C.F.R. §§ 410.28(a) and (e), 410.32(b) and 413.65.

• See also CMS Manual System, Pub. 100-02 Medicare Benefit Policy, Transmittal 137, Dec. 30, 2010 (Benefit Policy Manual, Ch. 6, §§ 20.4.4, 20.4.5, 20.4.6, 20.5.2, 20.5.3 and 20.7).
Supervision of Hospital (Provider) Outpatient Diagnostic Services (cont’d)

• What the “old” rule was perceived to be.
• The objective of the new rule: to conform the supervision requirements for hospital outpatient diagnostic services as much as feasible with the requirements for such services when reimbursed under the Medicare Physician Fee Schedule (e.g., services provided by physician groups and IDTFs).
Supervision of Hospital (Provider) Outpatient Diagnostic Services (cont’d)

• All services subject to general, direct or personal supervision.

• Be aware of the immediate availability, physical presence and physician qualification requirements.
Supervision of Hospital (Provider) Outpatient Diagnostic Services (cont’d)

• Be aware of how supervision requirements are stated in the radiology group’s exclusive provider agreement (if there is one in place).
  – Query whether only radiologists are qualified to provide supervision?
    • To our knowledge, no hospitals have taken this position, nor is such a position specifically mandated.
  – Also, the physical layout of a particular off-campus hospital (provider) outpatient department might drive which physicians may most expeditiously provide supervision (while also meeting the supervision requirements).
  – Exclusive provider agreements often impose some type of obligation on the radiology group to assist the hospital with regulatory compliance.
  – Best practice: clearly specify who is responsible for supervision.
Polling Questions #3

- What might be the biggest hurdle to overcome when converting to provider-based or under arrangement?
  
  a. Financial: minor reimbursement, a too costly conversion
  
  b. Operational: a fundamental change to the business model
  
  c. Inertia
  
  d. Lack of a good “partner”
Process for Conversion to Provider-Based or Under Arrangement

• Check state hospital licensing requirements to ascertain whether provider-based or under arrangements will work and what compliance steps, if any, will need to be taken (either before or after closing).

• In states with a CON or similar regime, analyze the CON implications.
  – If the imaging center already has a CON, can it be “transferred” or will the hospital only need to obtain a certificate of exemption or similar non-substantive review?
  – Can the center be added to the hospital’s existing CON?
  – Will the hospital be required to obtain a completely new CON and go through a full substantive review?
Process for Conversion to Provider-Based or Under Arrangement (cont’d)

• Do market and related research to ascertain:
  – Reimbursement differentials.
  – Non-governmental payor contracting biases and trends.
  – Can existing hospital payor agreements be accessed? Will they require amendment?

• Analyze a sample billing and collection data set.
Process for Conversion to Provider-Based or Under Arrangement (cont’d)

- Decide whether the conversion makes financial sense and whether the financial justification appears to be sustainable for the mid- to long-term.
  - Remember the transactional costs of getting the conversion done.
  - Also remember the potential reduction in equity value of the entity that owns the imaging center if it becomes an under arrangements contractor, disenrolls from Medicare, no longer has its own payor contracts, and changes from having multiple customers to having a single customer (i.e., the hospital).
Process for Conversion to Provider-Based or Under Arrangement (cont’d)

• If seeking provider-based status, fully understand the provider-based requirements and resolve among the participants how they will be satisfied.

• In other words, who will be responsible for what, and where will decision-making discretion sit on issues that are key to provider-based qualification?

• Memorialize the resolution in writing somewhere and have parties sign.
Process for Conversion to Provider-Based or Under Arrangement (cont’d)

• If necessary, for a joint ventured imaging center modify its organic documents, e.g., operating agreement and articles of organization (for a limited liability company).
  – Pay particular attention to buy-out rights and obligations, and related valuation methodologies: do they still make sense?

• Enter into or amend existing service agreements for subcontracted items and services.

• Enter into or amend management and medical director agreements.
  – Remember that for off-campus provider-based status, there will be significant limitations on the types and levels of administrative and management services that the hospital can contract out for, e.g., to the radiology group.
Process for Conversion to Provider-Based or Under Arrangement (cont’d)

• Enter into an agreement between the hospital and the joint venture that describes:
  – What will the joint venture do?
  – What responsibilities will stay with the hospital?
  – Where will decision-making discretion sit?
  – How will the joint venture be paid by the hospital?

• One alternative: flow all TC reimbursement to the joint venture, less a reasonable billing and collection fee for hospital and less any expenses attributable to responsibilities retained by hospital.

• Remember that hospitals are not always paid in a way that is conducive to segregating the TC reimbursement, so expect to build in mechanisms to determine formulaically the TC reimbursement in such circumstances, ideally subject to some type of annual or semi-annual reconciliation.
Process for Conversion to Provider-Based or Under Arrangement (cont’d)

• If necessary, modify any existing exclusive provider agreement with the hospital.

• Terminate (or modify) any professional services agreement between the joint venture and the radiology group.

• Be sure to address the supervision requirements for hospital outpatient diagnostic services: who is going to be responsible?
Roll-Up
Factual Scenario

• Existing provider-based outpatient imaging locations/centers, owned by one or more hospitals, and existing IDTFs, DRGPCs and/or other supplier-based imaging centers (owned by one or more radiology groups or non-physician entities/persons) are contributed into a new joint venture.

• In return, the previous owners become new owners of the new joint venture pro rata to value of locations/centers (and any other assets/cash) contributed.

• Joint venture then operates the locations/centers post-closing as provider-based or under arrangement.
Roll-Up Considerations

• Generally the same provider-based v. under arrangement analysis.

• However, a roll-up will inherently involve multiple locations/centers thereby making it much more likely that some may be on the campus of the main provider while others will be off-campus.

• As a result, the joint venture operating the locations/centers may be able to qualify certain ones as provider-based and operate the others under arrangements with the main provider.

  – Indeed, certain of the locations/centers could also potentially continue to be operated as DRGPCs or IDTFs.
Process for Roll-Up

- Do market and related research.
- Analyze a sample billing and collection data set.
- Expect that the provider-based and/or under arrangement analysis will be even more complex (because inherently there are more locations/centers involved).
- The overall transactional process will also be more complicated if multiple hospitals and multiple radiology groups are involved.
Process for Roll-Up (cont’d)

• The transaction will require documents for the formation of the joint venture:
  – Articles of organization and operating agreement (for a limited liability company, if that’s the entity of choice).
  – Asset contribution agreement.
  – Loan and/or other financing-related documents.
  – Management agreement(s).
  – Professional services agreement(s) (or modifications to any existing exclusive provider agreement(s)).
  – Possibly a master transaction agreement.
Process for Roll-Up (cont’d)

• Valuation will be a big economic issue to be negotiated (and will be particularly important if any of the providers are tax exempt).

• Also significant will be what outpatient imaging services (if any) that the hospital(s) will be allowed to continue to provide post-closing separate from the joint venture.
  – Needs to tie back to the valuation.
Thank you!

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