

Best Practices

Responding to the Paradigm Shift in Health Care Delivery: Health System Affiliation Strategies

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Health care reform continues to emphasize the perceived need to further integrate operations. The process of identifying potential hospital system affiliation partners requires risk assessment with regard to both (1) the optimal affiliation strategy and (2) the potential anticompetitive effects of an affiliation. It is also important for hospital systems to clearly identify and document the “pro-competitive” effects of a proposed affiliation. And, it is very important for hospital systems to effectively communicate the benefits of a potential affiliation to stakeholders, such as patients, employees, community leaders, physicians, and payers.

INTRODUCTION

The passage of The Patient Protection and Affordable Care Act¹ in the spring of 2010 proclaimed a new era for the health care industry. At one time, the most important factor of a hospital's success was its financial performance. Today, however, the important success factors for hospitals are beginning to shift to the quality of their clinical performance benchmarked against national standards.

Combined with an increased focus on integration, access to individual patient data, and reductions in payment rates, this change has created a paradigm shift in the payment of health care services from payment for volume to payment for quality. That paradigm shift will result in the redesign and consolidation of the entire health care delivery system.

The past few years have experienced profound changes in how the hospital industry is organized. Standing out among these changes was the extensive consolidation of hospitals through mergers and other affiliation strategies. These types of transactions are now proceeding at a dizzying pace not seen since the early 1990s.

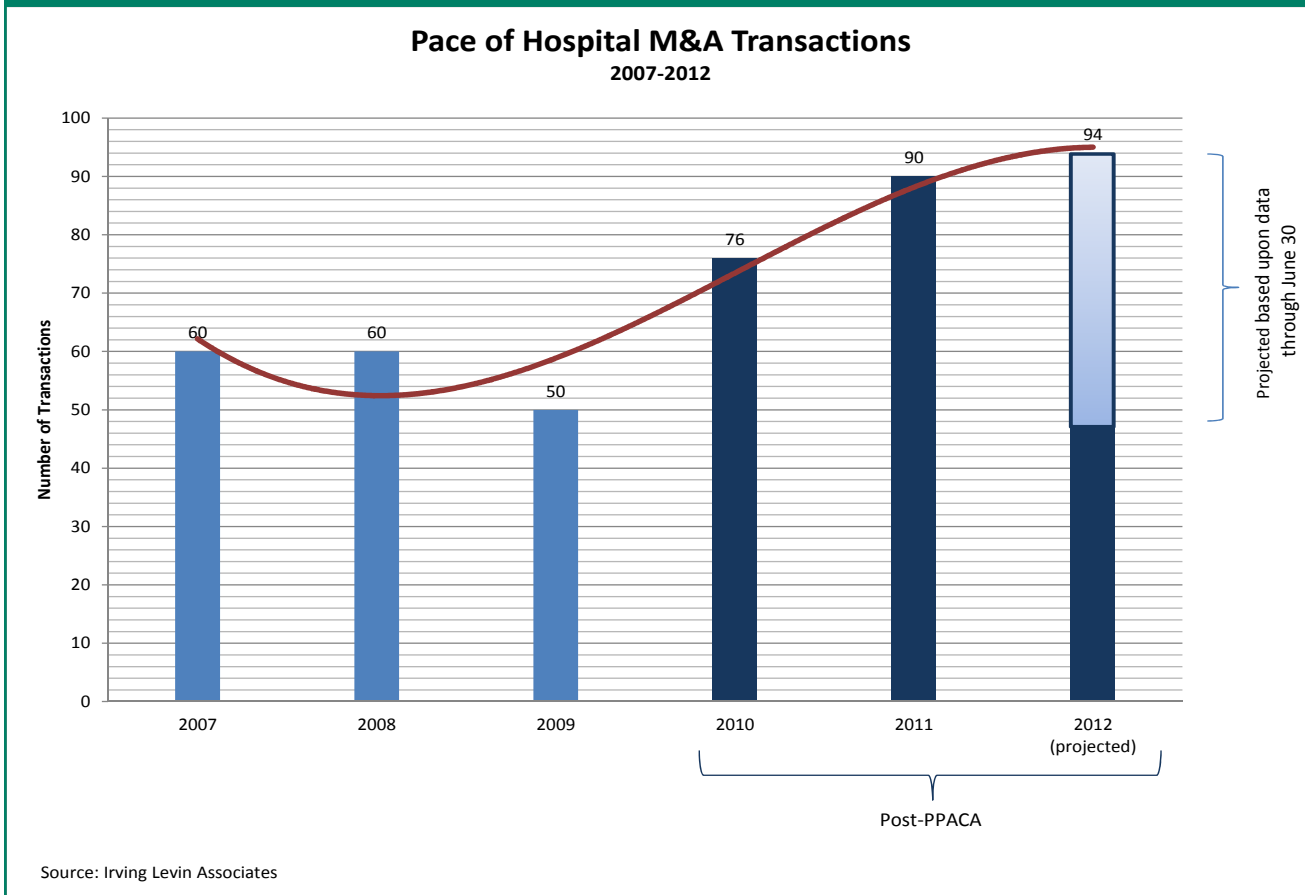
According to data reported by Irving Levin Associates, during the five-and-one-half-year period between January 1, 2007, and June 30, 2012, the hospital M&A market accounted for 386 transactions. However, the period of 2010, 2011, and the first six months of 2012 accounted for over 56 percent of all hospital M&A transactions during that five-and-one-half-year period.

If the first six months of 2012 are extrapolated, then 2011 and 2012 alone would account for over 42 percent of all hospital M&A transactions during the six-year period.² See Figure 1.

Those deals involved more than 96,000 acute care beds and generated combined net patient revenue of approximately \$62.5 billion (based on transactions for which prices were revealed).³ These statistics do not include hospital acquisition of physician practices or other affiliation/alignment strategies. Such strategies include the development of accountable care organizations or other loosely affiliated networks. Such transactions are also proceeding at a quick pace.

This momentum underscores the belief among leaders of hospitals and health systems, as well as

Figure 1
Pace of Hospital M&A Transactions
2007-2012



investors, that the aforementioned underlying economic and policy directions are unlikely to change. As a result, hospitals should pursue integration now or be left without a partner in the future.⁴

TRADITIONAL HOSPITAL AFFILIATIONS

Due to the changing landscape of the health care industry under health reform, most, if not all, hospitals have included a review of potential affiliations as part of their strategic plans. Although hospitals have been considering many different affiliation models, such as those emerging models discussed in the section below, the most common models settled on among hospitals seeking to fully integrate with a partner remain the traditional models of a merger, acquisition, or membership substitution.

These financially and clinically integrated models allow both hospital buyers and sellers to accomplish the following objectives:

1. Increase their leverage when contracting with commercial payers
2. Enter into new markets or secure positions in current markets
3. Improve access to capital markets under a singular obligated group

Brief Overview of Traditional Models of Affiliation

This discussion focuses on emerging strategies for affiliation. Therefore, we will only briefly discuss the characteristics of traditional models for affiliation.

The three basic models commonly used by hospitals resulting in a fully integrated corporate affiliation are summarized as follows:

1. Statutory Merger

In a statutory merger, two hospitals combine into one legal entity through the filing of Articles of Merger and a Plan of Merger with the state, typically leaving the larger

entity as the “surviving” legal entity in the merger. All assets and liabilities of the nonsurviving entity are combined with the assets and liabilities of the surviving entity.

All contracts with third parties of the nonsurviving entity are automatically assumed by the surviving entity by operation of law. The employees of the nonsurviving entity automatically become employees of the surviving entity unless otherwise agreed to by the parties in the definitive agreement and plan of merger.

2. Asset Purchase

In an asset purchase, a buyer hospital purchases substantially all of the assets and assumes most liabilities of the seller hospital in exchange for a specified purchase price.

The buyer will operate the hospital assets as set forth in the governing documents of the buyer or as otherwise negotiated in the definitive agreement with the seller. The selling hospital remains a separate legal entity after the sale of substantially all its assets. The selling hospital will wind down its affairs, liquidate any excluded liabilities, and dissolve.

As an alternative to dissolving, the selling hospital may restructure itself into another entity, such as a foundation that supports community health initiatives and monitors the buyer’s compliance with post-closing covenants.

At closing, the selling hospital will terminate employment of all employees and negotiate with the buyer regarding the hiring of most, if not all, of its employees in good standing. Buyer may choose to assume certain third-party contracts of seller in order to continue to operate the hospital. Such assumption of contracts may require notice or approval of those third parties.

3. Membership Substitution

In many not-for-profit health systems, the parent health system is the sole member of the subsidiary hospital entities. The parent will reserve certain rights over the subsidiary as specified in the governing documents of the subsidiary.

In a membership substitution model, the parent health system will become the sole member of the target hospital, resulting in the target hospital becoming a subsidiary of the health system parent.

Both entities will remain separate legal entities with separate governing boards, but the governing documents of the target hospital will be revised to insert the parent health system as the sole member with certain reserved powers over the target hospital, thereby becoming a subsidiary controlled by the parent health system.

FACTORS DRIVING HOSPITALS TO CONSIDER AFFILIATIONS

In the current environment of health reform, there are many reasons why hospitals are seeking affiliation partners. Sellers and buyers each have their own objectives when considering whether to affiliate.

Evaluating an Affiliation with a Larger Health System

There are a number of factors driving hospitals, specifically stand-alone community hospitals and small health systems, to affiliate with larger health systems. The usual reasons for finding a larger partner (e.g., access to capital, achievement of economies of scale, need to retain or grow market presence) are still applicable. However, changes under health reform have heightened these reasons and increased the urgency of finding a suitable partner before a competitor hospital gets to the table first.

A hospital undertaking a strategic process of finding a partner begins with identifying and prioritizing the key objectives and principles for such a partnership. This requires careful evaluation of all perspectives of important stakeholders, such as the community served by the hospital, patients, employees, medical staff, bondholders, creditors, donors, insurers, and regulators, to name a few.

In the current climate of health reform, the key objectives that hospitals consider for a partnership with a larger health system include the following:

■ Reputation for Quality of Care

Hospitals are seeking a potential partner that has a reputation for high quality care throughout the system, not just one line of business or area of service.

Under the new health care paradigm, reimbursement is tied to the quality of care being provided, not the quantity of care provided. Therefore, hospitals may be entitled to incentives or face penalties depending on the outcome of care provided to a patient.

“Communities around the country are facing physician shortages and such shortages are expected to rise given the expansion of insurance coverage under the PPACA and the growth and aging of the U.S. population.”

■ Level of Coordination across the Continuum of Care

Hospitals are assessing whether a potential partner meaningfully coordinates care for patients among care settings—from doctor’s offices to outpatient hospital services to inpatient acute services to home health care or nursing home care.

Health reform requires health systems to manage costs across a continuum of care as more services will be

bundled into a single payment (e.g., bundling payment for services that patients receive across a single episode of care, such as heart bypass surgery or a hip replacement, is one way to encourage doctors, hospitals and other health care providers to work together to better coordinate care for patients both when they are in the hospital and after they are discharged).

Additionally, more hospitals are taking on the risk of managing the cost and quality of care through accountable care organizations (ACOs).

■ Recruitment of Physicians to the Community

Hospitals are looking for the ties that a larger health system has with the physician community. Communities around the country are facing physician shortages and such shortages are expected to rise given the expansion of insurance coverage under the PPACA and the growth and aging of the U.S. population.⁶

In order to close this gap, provide or enhance service offerings, and improve the quality of care provided to patients, hospitals need to spend significant resources on (1) recruiting qualified physicians to the community and (2) providing them the support to flourish in their communities. This spending becomes especially important in small or rural communities where the recruitment of physicians is difficult and the shortage of physicians continues to rise.

Additionally, as more hospitals align with physicians through various mecha-

nisms (e.g., acquisition of physician practices, participation in an ACO, or contractual arrangements to co-manage clinical service lines), it is imperative that hospitals maintain and enhance their relationships with physicians before a competitor hospital aligns with those physicians.

■ Access to Capital

As an important part of affiliating with a larger health system, hospitals are reviewing the capabilities of a potential partner to provide them with significant capital to meet existing needs and improve their access to capital markets.

It is now routine that affiliation agreements will include covenants obligating the buyer to commit to the seller a certain level of capital over a period of time after closing. Affiliation agreements may even specify funding of certain capital projects, such as renovating or building new facilities, and purchasing new equipment and technology, including information technology, such as electronic health records.

Evaluating an Affiliation with a Stand-Alone Hospital or Smaller Health System

From the perspective of a larger health system, the reasons to pursue an affiliation with a stand-alone hospital or a smaller health system often relate to whether such affiliation will improve the strategic position of the larger health system, and not necessarily just its financial position.

When deciding whether or not to pursue an affiliation with a smaller hospital or health system, larger health systems consider the following, especially in light of the changes resulting from the PPACA:

■ Expanding Service Area

Larger health systems are considering whether an affiliation with a hospital will in fact increase their reach into communities needing the services offered by a larger health system. Specifically, they are evaluating whether they have current market presence in that service area, whether their medical staff members also visit hospitals in that community and whether there is a need for certain specialty or tertiary care services in the community that can serve as a referral source to the larger health system.

■ Defensive Strategy (“Not in my Back Yard”)

Larger health systems are throwing their

hat in the ring and responding to requests for proposals and confidential information memoranda from smaller hospitals as a defensive strategy because they do not want to lose out to another competitor in their market or simply do not want another health system in their market.

- **Addition of Physicians and Patients to Shared Savings and Quality Initiatives**

If a larger health system is currently participating (or desires to participate) in shared savings programs and quality initiatives with payers (e.g., ACOs), bringing more physicians and patients into the network allows the health system to spread the risk under those programs.

- **Increased Leverage in Contracting with Payers and Vendors**

As health systems add more facilities to their contracting arrangements with payers and vendors, they have more leverage in seeking better reimbursement for services from payers and deeper discounts from vendors.

- **Residual Liabilities of a Target Hospital**

Although a target hospital may appear attractive (e.g., located in a strategic market, will serve as a referral source for complex or tertiary care, may have significantly overlapping medical staffs), a deeper review of the hospital's operations may reveal liabilities that may be burdensome to assume. Specifically, liabilities related to the target hospital's compliance with regulations may result in future liability that is immeasurable at the time of due diligence.

PPACA increases the risk of violations under the federal Anti-Kickback Statute (AKS) and the False Claims Act (FCA).⁷

Specifically, the PPACA lessens the government's burden on proving intent under the AKS and clarifies that an AKS violation serves as a basis for a false or fraudulent claim under the FCA, thereby linking the two statutes and enhancing the penalties for violating the AKS.⁸

In order to provide protection to the buyer, it is commonplace that affiliation agreements will require the seller hospital (1) to provide a broad representation and warranty on its compliance with laws and (2) to provide an unlimited indemnification to the buyer for any liability resulting from a breach of such representation.

EMERGING STRATEGIES

While many hospitals continue to pursue the affiliations described above, some facilities are exploring alternative strategies designed to increase their prominence or viability in the marketplace without pursuing a traditional corporate affiliation or merger.

These emerging strategies, including joint ventures between investor-owned entities and not-for-profit health systems, creation of loosely affiliated care networks, creation of centers of excellence, and collaboration between health systems for back-end services only, are resulting in a new market dynamic.

Joint Venture Affiliations

Until recently, many not-for-profits would joint venture with investors only to address capital needs. These transactions were designed to provide the not-for-profit with an influx of capital while allowing them to retain both a governance role and an economic interest in the underlying entity.

In response to the paradigm shift occurring over the past couple of years, two new for-profit/non-profit joint venture models have emerged.

For-Profit/Nonprofit Joint Ventures

The first partnership model involves investor-owned entities and not-for-profit health systems designed to enable penetration of outlying markets that can serve as referral sources to the not-for-profit system.

Unlike many traditional not-for-profit transactions, which take the form of a cashless membership substitution or merger, these transactions usually involve a purchase price and capital commitment, and often result in the formation of a community foundation endowed through the transaction. The foundation is then tasked with enforcing the covenants of the transaction while providing additional health care resources to an often underserved community.

In addition, because the investor-owned firm owns a portion of the outlying hospital but not the larger hospital/health system partner, its interest in maintaining services in the community often aligns with that of the local board in maintaining and enhancing access to care in the local community.

These are the factors at play in recent transactions between Saint Thomas Health and Capella Healthcare in the Middle Tennessee and Southern Kentucky markets and LHP Hospital Group Inc., and Sacred Heart Health System Inc., in the Florida panhandle.



Effective May 1, 2012, Saint Thomas Health and Capella Healthcare formed a joint venture for the joint ownership and operation of Capella's four Middle Tennessee hospitals. Saint Thomas Health is a five-hospital system affiliated with Ascension Health while Capella Healthcare is a privately held hospital management company supported by over \$400 million in capital from the investment firm of GTCR Golder Rauner.

Going forward, the four Capella hospitals will operate as part of the Saint Thomas Health Network, which will hold an equity interest in each of the hospitals.⁹ Under the agreement, Capella will remain the managing member of the hospitals and the majority partner in the new joint venture.¹⁰

Additionally, Capella will be the exclusive development partner for Saint Thomas Health across Middle Tennessee and Southern Kentucky in any new acquisitions.¹¹

Saint Thomas Health, on the other hand, will become the tertiary care partner for the current hospitals and any newly acquired facilities, thus cementing additional referral sources.

Likewise, in April 2012, Sacred Heart Health System and LHP Hospital Group, through a newly created joint venture, entered into an asset purchase agreement and lease to operate Bay Medical Center located in Panama City, Florida. Sacred Heart Health System is a multi-hospital system in Florida and is also part of Ascension Health.

LHP Hospital Group is a privately held company established to provide essential capital and expertise to not-for-profit hospitals and hospital systems and is owned by affiliates of the private equity firm CCMP Capital Advisors, LLC.

Sacred Heart and LHP bought Bay Medical's non-real-estate assets, paid off its \$115 million debt, entered into a 40-year lease of the facility, and

established a foundation to fund unmet community health-related needs. The foundation will be funded with the remaining proceeds of the deal after retirement of its outstanding debt and the long-term lease payments.¹²

Additional terms of the deal include retention of all current hospital employees and a commitment to continue the services currently provided by the hospital for at least five years.¹³

The new hospital joint venture will allow Bay Medical Center to continue its charity care policy and other community benefit-related initiatives.

Academic Joint Ventures

The second partnership model involves partnerships between investor-owned entities and not-for-profit academic medical centers designed to leverage the capital resources of the investor entity and the brand, reputation, and access to experimental, innovative and technically sophisticated clinical services of the academic medical center in transactions in outlying communities.

Duke LifePoint Healthcare, a joint venture between Duke University Health System and LifePoint Hospitals, Inc., a publicly traded company with 51 hospitals, announced five such transactions in the past few years. In contrast to its first four deals, which were all located in close proximity to Duke's campus in Durham, North Carolina, on September 1, 2012, Duke LifePoint completed its acquisition of Marquette General Hospital, located in the upper peninsula of Michigan.

Prior to its acquisition by Duke LifePoint, Marquette General Hospital was actively exploring affiliation opportunities due to extensive capital requirements and its need to accelerate its physician recruitment and integration efforts in order to remain a competitive, financially stable institution.

A number of parties expressed interest in partnering with academic centers to make a proposal, but the combined track records and reputation of Duke and LifePoint, both individually and as partners, encouraged the Marquette General Hospital board to determine that they were the best candidate. Consequently, in June 2012, Duke LifePoint and Marquette General Hospital entered into an agreement for the purchase of the assets of Marquette General Hospital.

Recognizing that the Michigan Attorney General had authority over the transaction, both parties requested that the Michigan Attorney General review and approve the transaction prior to closing. The transaction was approved by the Michigan Attorney General on August 29, 2012.

Under the terms of the Asset Purchase Agreement, Duke LifePoint agreed to pay approximately \$147 million in exchange for substantially all of Marquette General Hospital's health care assets.¹⁴

The majority of the purchase price will go towards the satisfaction of Marquette General Hospital's outstanding liabilities, including unfunded pension liability and defeasance of outstanding tax-exempt bonds (approximately \$125 million), with the final \$23 million being used to fund the Marquette General Foundation (to be renamed Superior Health Foundation) to benefit the health of the greater Marquette, Michigan community.

Additionally, as part of the definitive agreement, Duke LifePoint agreed to invest \$350 million in capital improvement projects and physician recruitment over the next ten years. Proposed capital improvement projects include a state-of-the-art outpatient surgery center, comprehensive cancer center, private patient rooms, new technology, and new IT infrastructure.

Duke LifePoint also agreed to retain all current Marquette General Hospital employees and continue core services at the hospital for at least ten years.

Although the Duke LifePoint deal has received the most press recently, it is not the only example of investor-owned facilities partnering with academic medical centers. For example, Health Management Associates, a for-profit owner and operator of general acute care hospitals in nonurban communities located throughout the United States, and Shands HealthCare (University of Florida Academic Health Center) recently signed a letter of intent for the operation of Bayfront Medical Center in St. Petersburg, Florida.¹⁵

In each of these affiliation arrangements with academic medical centers, the academic partner can forgo both the capital expenditures required to develop a robust referral network and the management responsibilities at the acquired hospitals, which are duties assumed by the management partner. This results in the academic partner achieving greater economies of scale as well as a broader teaching and research environment.

The community hospital benefits from an influx of capital and reputation, and access to cutting edge academic medicine and clinicians, while the benefit to the investor-owned entity is largely one of branding, thereby enabling access to markets otherwise more difficult to penetrate without its academic partner.

While partnering with an investor-owned company is certainly not right for every organization or every situation, these new models of working together create opportunities for many not-for-

profits who wish to remain viable while responding to the shifting paradigm and extending their missions in ways not thought possible until now.

Loosely Affiliated Care Networks

Even health care systems not actively involved in mergers or other strategic acquisitions on the system level are still exploring other loose affiliations to distinguish themselves in the marketplace.

One such example of this loose affiliation is the development of the Mayo Clinic Care Network. For a negotiated fee, Network members receive access to Mayo's research and clinical expertise.¹⁶

While collaborating with other medical providers to provide the best possible care for patients has always been part of the Mayo Clinic culture and long-term success, the Mayo Clinic Care Network helps affiliated health systems benefit from this expertise to further enhance the lives of their patients.

The Mayo Clinical Care Network evaluates potential network partners through a rigorous set of clinical excellence, patient care, and quality criteria and is currently comprised of such institutions as NorthShore University HealthSystem in Evanston, Illinois; Dartmouth Hitchcock Medical Center in Hanover, New Hampshire; Sparrow Health System in Lansing, Michigan; and Yuma Regional Medical Center in Yuma, Arizona.

All Network members share a common commitment to improving the delivery of health care in their communities through high-quality, data-driven, evidence-based medical care. The main goal of the network is to help patients gain the benefits of Mayo Clinic expertise without necessitating travel to a Mayo Clinic facility.

The network achieves this goal by providing local physicians the opportunity to collaborate with





Mayo Clinic experts on diagnosis and treatment options for their patients and, should the need arise, streamline treatment at a Mayo facility. If a patient requires treatment at a Mayo facility, the Network is designed to facilitate coordinated, post-treatment care at the referring institution. This reduces the length of time a patient will need to be away from his/her home and family.

While the purpose of the Network is to increase the quality of care received by patients, an additional benefit is conferred on the local health system through the opportunity to add the Mayo Clinic Care Network logo and trademark to their marketing communications, thus providing a mechanism of distinguishing themselves within their local market.

Other institutions have developed similar care networks providing patients local access to a nationally recognized program or institution. For example, the Cleveland Clinic's Department of Cardiovascular and Thoracic Surgery and Department of Cardiovascular Medicine have entered into at least 14 subscription-based affiliations with other cardiothoracic surgery programs across the country, designed to allow the local department and its physicians access to the research, clinical expertise, training, and treatment protocols of Cleveland Clinic's heart program.¹⁷

Through these relationships, Cleveland Clinic provides affiliated programs with access to the latest in cutting-edge technologies, techniques, and management services, including clinical direction and quality assurance. In order to ensure the quality of the local institution's program, all affiliate surgeons are credentialed by the Cleveland Clinic and participate in required training, conferences, and educational programs provided by the Cleveland Clinic Heart & Vascular Institute.

The aforementioned examples are certainly not exhaustive, but merely representative of loosely affiliated care networks. These types of partnerships serve to enhance the care offered to patients at their local hospital by providing access to a network of experts, clinical protocols, and cutting edge research and procedures not available at the local institutions, while at the same time benefiting the collaborating institution through increased revenue by way of the subscription fee and increased market access for complicated cases outside of its geographic region.

Centers of Excellence

Another emerging strategy employed by select health systems is the use of centers of excellence targeting specific large employers and insurers through benefit design. While health systems have frequently used the term "center of excellence" over the past decade as a branding or marketing tool to highlight the quality of specific clinical services, some institutions have begun to leverage this concept beyond mere marketing.

For example, the Cleveland Clinic has partnered with Lowe Companies, Inc., a home improvement retailer with over 234,000 employees scattered throughout the country, on a three-year deal allowing those employees enrolled in Lowe's self-funded medical plan and their dependents to receive care at the Cleveland Clinic for certain cardiac surgeries, including open heart surgeries, valve repairs, and insertion of pacemakers.¹⁸

To take part in the program, the employee must be approved for the surgery in advance, be healthy enough to travel, and be able to schedule the surgery at a future date. For patients approved for the qualifying heart surgery, the Lowe's program will cover all medical deductibles and coinsurance amounts as well as travel and lodging expenses for the patient and a companion, plus concierge services to make the arrangements.

Likewise, Pepsi Co., has entered into a similar arrangement with Johns Hopkins for certain cardiac and joint replacement surgeries.¹⁹

These arrangements between large companies and health systems allow patients to receive high quality care by nationally recognized providers while reducing their out-of-pocket expense. Companies, in turn, benefit by paying a bundled rate for certain procedures, which in turn helps keep their costs down. Health systems benefit by ensuring a steady volume of patients for their well-respected, high margin clinical areas.

Collaboration for Back Office Services and Sharing of Best Practices

Another strategy employed by health systems in an effort to continue streamlining costs and respond to the changing care environment is the development of formal collaboratives. On October 24, 2012, four not-for-profit health systems in the Midwest announced their partnership to create The BJC Collaborative, L.L.C.: CoxHealth of Springfield, Missouri; BJC HealthCare of St. Louis, Missouri; Memorial Health System of Springfield, Illinois; and Saint Luke's Health System of Kansas City, Missouri.²⁰

Under this Collaborative, the four health systems will continue to operate independently but will share services, costs, and best practices whenever possible.

The news release reports that the Collaborative is “buoyed by the tenets of the Patient Protection and Affordable Care Act that encourage partnerships and innovation to improve patient outcomes and reduce health care costs.”²¹

The goals of the Collaborative are as follows:

1. Focus on achieving savings
2. Deploy clinical programs and services to improve access to and quality of health care for patients
3. Lower health care costs
4. Create additional efficiencies that will be beneficial to patients and the communities served by the member organizations

The Collaborative has made it clear that the four systems have not discussed a merger. The president and CEO of BJC HealthCare, who is also the board chairman of the Collaborative, has stated that the four systems have not considered a merger because they are “financially sound” and “don't need money from one another.”²²

Organized as a limited liability company, the four health systems will have equal membership in the Collaborative. The CEO of each system and a representative of each system's board will serve as the voting members of the board of directors of the Collaborative.

Initially, the Collaborative will not have its own employees or a physical location. Instead, the work of the Collaborative will be carried out by four operating committees to explore computer systems, contracted services and energy management, medical equipment maintenance, and supply chain.

Four “roundtables” also will be formed to share information on clinical quality and patient service, employee benefits, professional development and regulatory compliance.

Because the Collaborative is focused on reducing expenses through integration or coordination of the “back office” and through sharing clinical best practices, there is less antitrust risk than if the Collaboration was used to negotiate pricing with payers or setting salaries with employees.

This model of affiliation aims to get the best out of an affiliation (e.g., economies of scale, sharing of best practices) without giving up independence, taking on liabilities of other partners, or having to maneuver through the process of integrating operations and cultures.

LEGAL ANALYSIS OF AFFILIATION STRATEGIES

There are a myriad of federal and state laws and regulations that need to be analyzed when determining the appropriate affiliation strategies for a hospital. Each law may have varying significance depending on the particular circumstances of the hospital and the affiliation strategies being pursued (e.g., not-for-profit, tax-exempt hospital affiliating with a for-profit, taxable health system).

These laws include antitrust laws, fraud and abuse laws, federal tax-exemption law, state laws requiring certificates of need for change of ownership of a hospital, and states requiring attorney general review and approval prior to the transfer of charitable assets.

Antitrust laws stand out among these laws given the uptick in enforcement activity by the Federal Trade Commission (FTC) and the U.S. Department of Justice (DOJ) in health care industry transactions. Even though the majority of affiliations among health care providers are not challenged by the FTC, those that are challenged provide important lessons on evaluating and overcoming the potential competitive concerns of an affiliation.

Examples of recent antitrust enforcement activities by the FTC include its challenge of the affiliation of Rockford Health System (Rockford) and OSF Healthcare System (OSF) in Rockford, Illinois;²³ the consummated affiliation of ProMedica Health System (ProMedica) with St. Luke's Hospital (St. Luke's) in Toledo, Ohio;²⁴ and the acquisition by Phoebe Putney Health System (Phoebe) of Palmyra Park Hospital (Palmyra) in Albany County, Georgia.²⁵

Under the proposed affiliation between Rockford and OSF, two of the three hospitals in Rockford, Illinois—Rockford Memorial Hospital (owned by Rockford) and St. Anthony Medical Center (owned by OSF)—would combine and form the OSF Northern Region, a new health care system. Although the

“... institutions and their governing bodies must demonstrate a willingness and courage to respond to challenges posed by this new era.”

nant health system that would control 64 percent of the market for general acute care inpatient services and would combine two of the three primary care physician groups in the area, representing 37 percent of the physician market.

OSF and Rockford argued that the current and future regulatory climate (citing to provisions in the PPACA) favors the efficient delivery of health care services and that by combining resources and reducing costs (including costs related to redundancy in service offerings), the hospitals could compete more effectively in the environment and satisfy the aims of health care reform.

The court found in favor of the FTC and granted the preliminary injunction, finding that the efficiencies and improvements from the affiliation could be realized without the affiliation or were too speculative to overcome the anticompetitive effects. On April 12, 2012, OSF and Rockford announced that they were ending efforts to affiliate the two organizations.²⁶

In the ProMedica and St. Luke's affiliation, the parties signed a Joinder Agreement under which ProMedica became the sole corporate member of St. Luke's via a membership substitution model. A few months thereafter, the FTC opened an investigation into the transaction.

Although still under FTC investigation, the hospitals closed the transaction but entered into a Hold Separate Agreement which prevented ProMedica from terminating St. Luke's contracts with health plans, eliminating or consolidating clinical services at St. Luke's, or terminating any St. Luke's employees without cause.

After closing the transaction, the FTC filed an administrative complaint against ProMedica alleging that the affiliation threatened to substantially lessen competition for health care services in Lucas County, Ohio, in violation of Section 7 of the Clayton Act.

affiliation was approved by the Illinois Health Facilities and Services Review Board (which granted OSF a Certificate of Exemption), the FTC filed an administrative complaint in November 2011 and moved to enjoin the affiliation in federal court.

Among the allegations in the complaint, the FTC asserted that the affiliation would create a dominant

The FTC found that the affiliation was illegal and imposed a remedy requiring ProMedica to sell St. Luke's to its previously independent parent and restore its status as a hospital independent from ProMedica. ProMedica has appealed the FTC's decision to the Sixth Circuit Court of Appeals and the parties are currently preparing legal briefs.

In the Phoebe and Palmyra affiliation, the parties engaged the Hospital Authority of Albany-Dougherty County (a state authority) to acquire Palmyra (using Phoebe funds) and then lease-back the Palmyra assets to Phoebe for a nominal amount.

The FTC challenged the structure of this transaction, alleging that the parties included the Hospital Authority for no reason other than to circumvent antitrust laws and bring the transaction within the immunity of the state action doctrine.

The FTC claimed that the transaction would substantially lessen competition in the market for acute care services in southwestern Georgia given that Phoebe's only competitor in a six-county geographic market was Palmyra and the two hospitals account for over 85 percent of the acute care provided in that market.

Phoebe successfully overcame the FTC's challenge in both the district and appellate courts. However, the U.S. Supreme Court has granted certiorari to review the FTC's challenge. A decision is expected by June 2013.

As hospitals begin the process of identifying potential affiliation partners, it is important to conduct a risk assessment of the potential anticompetitive effects of such an affiliation early on in the process. It is also essential to identify and document the pro-competitive effects of the transaction and communicate such benefits to stakeholders, such as payers, community leaders, physicians, and employees.

SUMMARY AND CONCLUSION

While health care reform has created a paradigm shift in the payment of health care in the United States, it is the redesign of the care delivery systems that poses the greatest challenge in the years to come.

In assessing each institution's affiliation strategy, one size does not fit all, and strategies must be narrowly tailored to each institution's culture and market dynamics.

In this rapidly changing landscape of the health care industry, new and innovative ideas are constantly being developed and institutions and their governing bodies must demonstrate a willingness and courage to respond to challenges posed by this new era.

Notes:

1. Pub. L. Nos. 111-148 and 111-152 (hereinafter, collectively, "PPACA").
2. Irving Levin Associates, *The Hospital M&A Market Report*, Third Edition, 2012.
3. Id.
4. See Anna Wilde Mathews, "Health Deals Going Strong," *Wall Street Journal* (June 26, 2012) available at <http://online.wsj.com/article/SB10001424052702304458604577490910017145108.html?user=welcome&mg=id-wsj>.
5. Although the terms "buyer" and "seller" are used in the context of an asset purchase model, these terms are used herein to refer to a smaller hospital or health system as the "seller" and a larger health system as the "buyer" even if other models of affiliation are used.
6. See "Physician Shortages to Worsen Without Increases in Residency Training," American Association of Medical Colleges (AAMC), available at https://www.aamc.org/download/153160/data/physician_shortages_to_worsen_without_increases_in_residency_tr.pdf; see also Annie Lowrey and Robert Pear, "Doctor Shortage Likely to Worsen With Health Law," *New York Times* (July 28, 2012), available at <http://www.nytimes.com/2012/07/29/health/policy/too-few-doctors-in-many-us-communities.html>.
7. The federal Anti-Kickback Statute (AKS) is a criminal statute that prohibits the exchange (or offer to exchange) of anything of value in an effort to induce or reward the referral of federal health care program business. See 42 U.S.C. Section 1320a-7b; the federal False Claims Act (FCA), among other things, imposes significant penalties on any person who submits a claim or statement to the federal government that he or she knows (or should know) is false or fraudulent. 31 U.S.C. Section 3729.
8. PPACA, Section 6402(f).
9. See Saint Thomas Health, "Saint Thomas Health, Capella Healthcare Finalize Innovative Partnership--New Venture will Serve Hospitals in Middle Tennessee and Southern Kentucky" (April 30, 2012), available at <http://www.sths.com/news.php?id=5&loc=sths>.
10. Id.
11. Id.
12. See Bay Medical Center, "Bay Medical Center Submits Lease Document to the Bay County Commission for Review" (December 5, 2011), available at <http://www.baymedical.org/About-us/Latest-News/Articles/Bay-Medical-Center-Submits-Lease-Document-to-the-.aspx>.
13. Id.
14. See State of Michigan Attorney General Bill Schuette, "Proposed Sale of Marquette General Hospital to Duke LifePoint," available at http://www.michigan.gov/ag/0,4534,7-164-17337_61487-277835--,00.html.
15. See "Bayfront Partners with Health Management Associates, Shands," *Tampa Bay Business Journal* (October 25, 2012), available at <http://www.biz-journals.com/tampabay/news/2012/10/24/bayfront-partners-with-health.html>.
16. See Mayo Clinic, "Mayo Clinic Care Network" available at <http://www.mayoclinic.org/care-network/>.
17. See Cleveland Clinic, "Heart & Vascular Affiliates" available at <http://my.clevelandclinic.org/heart/departments-centers/heart-vascular-affiliates.aspx>.
18. See Cleveland Clinic, "Low's Expands Heart Healthcare Benefits with Cleveland Clinic" (February 16, 2010), available at http://my.clevelandclinic.org/news/2010/lowes_expands_heart_healthcare_benefits.aspx.
19. Victoria Stagg Elliott, "Large Companies Try Domestic Medical Tourism," *American Medical News* (January 9, 2012), available at <http://www.ama-assn.org/amednews/2012/01/09/bisb0109.htm>.
20. See Saint Luke's Health System, "Saint Luke's Health System Announces Partnership in The BJC Collaborative: Four Leading Not-for-Profit Health Systems Announce Formal Partnership" (October 24, 2012), available at <https://www.saintlukeshealthsystem.org/news-release/saint-luke-s-health-system-announces-partnership-bjc-collaborative>.
21. Id.
22. Beth Kutscher, "Bang without the Buck? Bypassing Merger, Four Systems Look for Buying Power, Reduced Costs with Collaboration," *Modern Healthcare* (October 27, 2012), available at <http://www.modernhealthcare.com/article/20121027/MAGAZINE/310279960>.
23. In the Matter of OSF Healthcare System and Rockford Health System, FTC Docket No. 9349 (Nov. 17, 2011) available at www.ftc.gov/os/adjpro/d9349/111118rockfordemtp.pdf.
24. In the Matter of ProMedica Health System, Inc., FTC Docket No. 9346 (March 28, 2012) available at www.ftc.gov/os/adjpro/d9346/120328promedica-brillopinion.pdf.
25. *FTC v. Phoebe Putney Health Sys.*, 663 F.3d 1369 (11th Cir. 2011), cert. granted, 80 U.S.L.W. 3707 (U.S. June 25, 2012) (No. 11-1160).
26. OSF Healthcare System, "Health Systems Agree to Discontinue Pursuit of Affiliation" (April 12, 2012), available at <http://www.osfhealthcare.org/news/2012/release-041212-001.html>.



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