

NAVIGATING THE COMPLEXITY

Nonprofit Transaction Approvals





Introduction



In response to a myriad of factors, healthcare providers continue to align vertically and horizontally using traditional and innovative structures designed to improve quality, increase efficiency, and lower the cost of care. These alignments often take the form of mergers, acquisitions, joint ventures, or other affiliation structures (hereafter, “consolidations”) that implicate various state laws. For example, many states have laws requiring that the parties to such consolidations obtain the state attorney general’s consent to the transaction.¹

Consolidations of healthcare providers may be accomplished through a number of arrangements that require unique considerations and analysis beyond traditional valuation methods. In addition, the healthcare industry’s current evolution from a volume-based, fee-for-service payment system to a value-based payment system is altering valuation metrics, and creating potential opportunities and pitfalls that did not exist in the past payment landscape.

As a result, healthcare providers, their boards of directors, and their counsel increasingly require the assistance of advisors well-versed in healthcare transactions and healthcare reform, and who understand what regulatory oversight bodies will expect from the advisor’s analysis. In addition to traditional valuation principles, experts advising parties and regulators regarding a healthcare consolidation must be equipped to assess the consolidation’s benefit to the community in terms of quantifiable economic impacts; implications for local hospital governance; and impact on quality of, access to, and cost of care.

Furthermore, consolidations may require knowledgeable advisors to conduct post-transaction monitoring or auditing to assess adherence to the terms of the consolidation. Such advisors must have a unique blend of expertise in the regulatory, financial, business, clinical, and data analytical aspects of the healthcare industry—including an understanding of new payment models and their impact on delivery of healthcare.

This white paper will discuss some of the state regulatory parameters that may impact consolidations and the analysis and expertise required to ensure that consolidations benefit communities and improve quality and efficiency, while controlling the cost of healthcare.

¹ More than 20 states have statutes that specifically govern transfers of nonprofit hospital system assets. Office of Legislative Research, *Nonprofit Hospital Conversion Laws in Other States*, September 30, 2014. <http://www.cga.ct.gov/2014/rpt/pdf/2014-R-0229.pdf>, accessed November 11, 2014.



Attorney General's Consent to the Transaction

Many states have laws authorizing the state's attorney general to review and act in a manner necessary to protect charitable assets within the state.² Some states have statutes specifically directed at nonprofit healthcare providers, and those statutes typically apply to conversions from nonprofit to for-profit status. However, regulatory review of transactions involving one or more nonprofit organizations is common. Typically, these statutes require parties to a proposed sale or merger of such providers to first give notice to, and obtain the consent of, the state's attorney general.³

For example, Georgia's Hospital Acquisition Act⁴, requires the parties to give notice to the attorney general and obtain his or her review and consent to nonprofit hospital acquisitions occurring in the state of Georgia. The form of the notice is prescribed by statute and requires significant documentation, including a valuation of the hospital or its assets. The seller and the attorney general must each engage an expert.⁵ The seller's expert must prepare a financial and economic analysis, including whether the seller will "receive fair value for its assets" or, in the case of a nonprofit to nonprofit transaction, whether the seller "will receive an enforceable commitment for fair and reasonable benefits for its assets." Likewise, Georgia's attorney general must engage an expert to review the reports of the parties' experts and testify at a public hearing.

Based on the notice filing and the experts' reports, the attorney general must determine whether the proposed disposition of the nonprofit hospital's assets is "in the public interest"—that is, whether the transaction is authorized, whether the value of the charitable assets is safeguarded, and whether any proceeds of the transaction are used for appropriate charitable healthcare purposes. In essence, the attorney general must determine whether there will be sufficient and appropriate community benefit from the transaction.



² See, e.g., Michigan Nonprofit Corporation Act, MCL 450.2301; Michigan Supervision of Trustees for Charitable Purposes Act, MCL 14.251.

³ See, e.g., California Corporation Code §§ 5914-5925; Title 11 California Code of Regulations § 999.5;

⁴ O.C.G.A. §31-7-400 et. seq.

⁵ In practice, this expert is often jointly engaged by the seller and buyer.



Community Benefit Analysis in the Healthcare Industry

The extensive analysis and findings required by the Georgia statute illustrate the depth and breadth of expertise required of the parties' consultants to obtain approval of a nonprofit hospital acquisition. Many healthcare transactions are not straightforward acquisitions, especially when the transaction is between two nonprofit entities. Member substitutions, mergers, joint operating agreements, leases, and other potential organizational structures often require approaches beyond the traditional fair market value analysis. Other considerations to determine benefit to the community might include:

Parties' motivation.

The business case for aligning two organizations must be considered when determining the community benefit. When transactions include an urban tertiary referral center and a small community hospital, the urban center will often commit to maintaining certain services in the community and providing access to capital. In these scenarios, urban organizations have determined that a capital investment in a rural facility to keep patients in the community is more efficient than expanding capacity in an urban setting. In other cases, allocating overhead expenses from urban centers to rural critical access hospitals can result in a collective financial benefit for the combined organization. Understanding and articulating the "win-win" for both parties to the transaction can illustrate to the attorney general that the parties are aligning for the community's benefit.

Assumed liabilities.

Member substitution arrangements, where a health system (Buyer) assumes the assets and liabilities of an organization (Seller), are becoming more typical. If the Buyer has a better credit rating than the Seller, the Buyer's participation may enable the Seller to restructure debt and payment terms on other liabilities to reduce interest expense and improve cash flow.

In certain lease arrangements, the lessee will make lease payments to the lessor equivalent to the debt services owed by the lessor. The willingness to assume these liabilities can provide a significant benefit to the community, the value of which should be included in the analysis of the transaction.

Investment to cover on-going losses.

In dire financial situations, a health system may choose to extend a line of credit to a struggling hospital or health system to keep the hospital open and providing services to the community. While the line of credit is often secured by an unencumbered asset of the struggling organization (if available), the willingness to assume the risk of loaning funds to provide working capital to a struggling hospital indicates the value the health system places on the organization. The community benefits from such an extension of credit--not only from having access to healthcare, but also from the economic impact of the hospital's continuing operations.

Value of continuing operations.

Community hospitals are usually one of the largest employers in the community. When a transaction provides security to a struggling community hospital, the economic benefit of keeping the hospital in the community should be considered. Organizations such as the American Hospital Association (AHA) provide studies to demonstrate the economic impact of hospitals based on the number of employees and other operating expenses borne by the hospital which support the community economically. These studies can be used to estimate the value of a hospital's operations on the community's economy.

Benefits from capital expenditures.

When two nonprofit organizations align through a structure other than acquisition, one party will often commit to funding a pre-determined capital investment. These projects are frequently related to new or renovated buildings and information technology improvements. Capital used for construction may result in an economic earnings multiple well above the cost of construction. The benefit to the community of these capital expenditures can be estimated using Bureau of Economic Analysis (BEA) data.

Specific Contractual Terms.

Contract terms such as transfer provisions and rights of first refusal must be evaluated to determine how they impact the community and its charitable assets. In lease arrangements,

transfer provisions must be carefully assessed to determine if the community is receiving sufficient value for the transferred asset. Rights of first refusal can benefit a community if they allow the community to exert control regarding the selection of potential future buyers. The value of this control should be included in the assessment of community benefit.

Retained local governance.

Despite the many technological advances such as telehealth and remote patient monitoring, healthcare remains, for the most part, a local endeavor. Patients in the community often have many ties to their local hospital and support it with their patronage and donations. In addition, nonprofit healthcare providers are typically governed by a board of community leaders, which further enforces community loyalty to the nonprofit provider. Thus, the potential impact of a change in local governance must be considered when valuing a proposed consolidation.

Assessing the community benefit of a nonprofit hospital acquisition requires capabilities and experience beyond a traditional fair market value determination. It requires financial, economic, regulatory, clinical, and market analysis expertise. As the healthcare industry evolves, it becomes ever more critical that the parties to nonprofit consolidations, and the regulators that oversee them, retain advisors with expertise specific to the healthcare industry.





Additional Expertise Required Due to Healthcare Payment & Delivery Reform

The current volatility of the healthcare market calls for yet an additional layer of expertise when evaluating potential consolidations. Payment and delivery reform programs that were set in motion by the passage of the Patient Protection and Affordable Care Act (ACA) have been implemented and are now beginning to impact healthcare organizations financially and operationally.

Payment and Delivery Reform Initiatives

The Centers for Medicare & Medicaid Services (CMS) has implemented several initiatives intended to encourage quality by imposing penalties for hospitals' failure to meet certain standards (referred to in this paper as "payment reform initiatives").

Hospitals are now beginning to feel the impact of these programs. For example, under the Hospital Value-Based Purchasing Program (HVBP), a hospital can receive a Medicare payment reduction of up to 1.5% in 2015 (and up to 2% reduction in 2017). In 2015, hospitals could also be subject to readmission penalties of up to 3% for certain patients under the Hospital Readmission Reduction Program (HRRP) and a 1% penalty under the Hospital Acquired Conditions Reduction Program (HAC Reduction Program). The Department of Health and Human Services (HHS) has set a goal of tying 90% of all traditional Medicare payments to quality or value by 2018 through programs such as the HVBP and the HRRP.

Hospitals that employ physicians might also be impacted by the Physician Value Modifier (VM Program), the Physician Quality Reporting System (PQRS), and meaningful use penalties. These programs are being phased in and are now beginning to impact physicians' Medicare reimbursement. By 2017,

a physician could experience a total downward payment adjustment of -9.0% under these three programs. That number grows to -10% in 2018 and -11.0% in 2019 as the meaningful use penalty increases. These programs present both opportunities and risks that must be evaluated in a potential consolidation. (For more detail regarding the VM Program, see PYA's whitepaper, [The Practical Guide to the Medicare Physician Value Modifier Program.](#))

In addition to these payment reform initiatives, CMS has piloted and implemented a number of delivery reform initiatives. One such initiative is the Medicare Shared Savings Program (MSSP), which promotes efficiency and cost savings by allowing participants in an Accountable Care Organization (ACO) to share in any savings they generate by reducing the cost of care (subject to quality standards) for Medicare beneficiaries. Another initiative is the Bundled Payment for Care Improvement Program (BPCI) which rewards participants with savings they can achieve over a budgeted amount

for all care provided during certain episodes of care. HHS has set a goal of year-end 2018 to have 50% of traditional, fee-for-service Medicare payments tied to quality or value through alternative payment models such as

ACOs or bundled payment arrangements. As these delivery reform initiatives become the norm, a hospital's value will depend, in large part, on its participation (or readiness to participate) in these delivery reform initiatives.

To avoid penalties and position themselves to enjoy the benefits of payment and delivery-reform initiatives, hospitals must pursue a comprehensive strategy that includes quality improvement, patient satisfaction, and efficiency initiatives; health information technologies and competencies; clinical integration strategies; and value-based physician compensation structures.

Review and Evaluation of Healthcare Reform Readiness

The cumulative impact of incurring these penalties, or not realizing the benefits of these programs, could significantly affect the valuation of a proposed consolidation. Therefore, expert review of a proposed consolidation should include assessment of:

- The healthcare reform readiness of the hospital to be acquired—that is, to what degree the hospital has the necessary organizational, clinical, and technological infrastructure to avoid some or all of the penalties and realize the benefits of the reform initiatives described above.
- The benefit to the community of improved clinical quality and outcomes that would result from such an investment.
- The financial impact on the acquired hospital of anticipated penalties, if any.
- The expert review also should consider the buyer's performance related to payment and delivery reform programs, including:
- An assessment of the buyer's participation (or readiness to participate) in the payment and delivery reform initiatives.
- The investment that would be required to implement necessary organizational, clinical, or technological improvements to avoid penalties and maximize quality and reimbursement.
- A determination of whether the buyer has the managerial, financial, and operational resources to improve the readiness of the hospital to be acquired.



Such a review requires experts with financial, regulatory, clinical, and analytical capabilities, as well as an extensive breadth and depth of understanding of the healthcare industry. To truly evaluate the viability and value of a healthcare provider, the expert not only must be proficient in traditional valuation methodologies, but also must understand the current and future healthcare regulatory and payment structure.



Post-Transaction Auditing or Monitoring

Even after a consolidation is approved, the parties will likely need expert assistance to monitor and assure continued compliance with the terms of the consolidation. For example, the Georgia Hospital Acquisition Act gives the attorney general “authority to ensure compliance with any and all notices, certifications, obligations, and commitments which are required to be made in connection with a transaction

[under the Act]” and allows the attorney general to “institute proceedings to enforce such compliance” in state court.⁶ Thus, it is incumbent upon the parties to audit and maintain compliance with the agreed-upon terms of the consolidation to assure that it continues to benefit the community. Failure to do so can result in expensive and time-consuming litigation down the road.

In February 2015, HCA Midwest agreed to pay \$15 million to settle a portion of an ongoing legal battle with Health Care Foundation of Greater Kansas City. The litigation relates to HCA’s contractual obligations arising from its 2003 purchase of the nonprofit Health Midwest hospital system. When HCA purchased the system, HCA agreed to provide at least \$653 million in charitable donations and uncompensated care and \$450 million in hospital improvements over 10 years. Litigation continues regarding whether HCA has met its obligations to fund building improvements.



Conclusion

In short, statutory protections for nonprofit healthcare providers have long required expert analysis and opinion. However, the current environment of rapid change in the healthcare industry now more than ever requires a deeper and broader expertise. This expertise must include not only traditional valuation principles, but also an understanding of the evolving payment and delivery models and the clinical, organizational, operational, and technological resources that will be required for healthcare providers to remain viable and continue to provide benefit to their communities.



⁶ O.C.G.A. §31-7-407.



PYA Can Provide the Expert Assistance You Need

PYA is a certified public accounting and healthcare consulting firm that provides timely insight and strategic direction, helping our clients thrive in the midst of rapid change. For more than three decades, we have provided clients with world-class support, delivering comprehensive services in valuation, accounting, and compliance and cutting-edge insights and assistance to healthcare providers seeking to understand and prepare for healthcare payment and delivery reform.

PYA is well-versed in the complex business and regulatory environment of the healthcare industry. As such, we have

a unique understanding of the issues surrounding consolidations of nonprofit providers and the ability to assess the community benefit of the proposed transaction—even in the rapidly changing environment of healthcare payment and delivery. Whether you are: (1) counsel for a healthcare provider seeking to acquire a nonprofit hospital, or (2) a state agency seeking expert review, auditing, or monitoring of such transactions, PYA's professionals can assist with valuation, strategic planning, organizational structuring, financial analysis, economic impact analysis, data analysis, auditing, and monitoring.

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