

Independent Partners

Unlike mergers or sales, noncontrol deals preserve local governance

By John Callahan, Patrick Allen and Stephen Wu

Much attention has been paid to consolidation in the U.S. hospital industry in the wake of the Affordable Care Act. The drivers of the trend are easy to spot — revenue pressure, a changing physician landscape and the need to do more with less. Cost efficiencies and clinical scale are of interest to many health systems, even without the strategic and defensive drivers that underlie many hospital transactions.

Much of the press coverage of hospital deals, however, has focused on two types of transactions: proprietary hospital companies' purchase of community hospitals; and large nonprofit systems' acquisition of smaller ones. These transaction types differ from an increasing number of transactions in which a change of control does not occur. In these noncontrol transactions, a community hospital or health system preserves some degree of independence, usually characterized by an ongoing role for a local community board in the governance of the hospital. While there can be meaningful benefits for both parties, there are

some limitations on what can be accomplished through their use.

Noncontrol Transactions

A noncontrol transaction is a hospital affiliation that does not involve the sale of a majority interest in a hospital or a transfer of a majority of governance control over a hospital. While many names and variations exist, some of the more common noncontrol transactions include:

- **Special member models**, in which a larger hospital or system takes a minority interest in a smaller one, in exchange for financial and programmatic investments;
- **Branding arrangements**, which are designed to leverage the name, clinical expertise or physician platform of a system or academic medical center on behalf of an unaffiliated hospital or system;
- **Management and joint operating arrangements**, either for discrete service lines or whole hospitals.

Non-takeover transactions may be attractive to community health systems because they offer an opportu-

nity to partner with a larger organization to help support capital or programmatic needs, while allowing the community system to maintain more control over its assets and destiny than in takeover transactions. In some cases, a noncontrol transaction allows a community system to take a larger partner for a test drive, recognizing that a fuller transaction between the parties only can occur after further bridges of trust and collaboration are built between and proven within the organizations.

Noncontrol transactions also can be attractive for larger health systems for a number of reasons. The programmatic and governance arrangements align some financial and clinical interests of the parties, usually fostering collaboration related to patients' requiring tertiary or quaternary care who might be better treated at the larger system's facilities. In some cases, the arrangements include non-competition covenants and rights of first refusal that benefit one or both parties. If the transaction makes the community health system less attrac-

tive to other strategic partners, the larger system may be more willing to make lasting programmatic investments in light of the defensive benefits it gains.

Usually, noncontrol transactions involve financial commitments in the form of an investment by one of the parties in the other, or in a joint venture entity. The nature of the investment can take the form of a loan, a membership interest stake or a contractual right to share in earnings. Noncontrol transactions often include specific clinical and programmatic commitments by one or both parties.

Governance and Control

Although a smaller hospital or system retains majority interest in the organization and governance control through a noncontrol transaction, the larger system will gain a voice in governance. At a minimum, governance rights usually are structured to protect the larger system's investment. The larger system often will have the right to approve a decision to shut down, curtail or sell facilities financed with capital the system contributed. Without such basic governance controls, the investment made by the larger system would be more akin to a passive, alternative investment (without the high rate of return that other alternative investments promise).

In many cases, the larger system will be given one or more seats on the smaller system's governing board or the board overseeing the operation of the relevant service lines. Other governance rights are negotiated on a case-by-case basis; however, applicable antitrust laws may impact the two entities' activities when governance rights are not consolidated within a single, governing board.

Antitrust Limitations

When two health systems compete in any service line, antitrust laws prohibit them from engaging in illegal price-fixing or market or service allocations, among other potential antitrust violations. This restriction

is interpreted broadly and prohibits competing hospitals from jointly contracting, jointly planning strategy or sharing competitively sensitive information, such as wage rates, capital plans or pro forma financial statements. When the competing systems are sufficiently integrated in a legitimate venture that is governed by a single entity, such as a common parent organization, they cease to be competitors and become incapable of colluding for antitrust purposes.

As a practical matter, prohibitions on unlawful collusion can impact how noncontrol transactions are structured and the manner in which the newly affiliated hospitals are operated. The less control that the larger system has over the smaller, the more limitations there will be on their ability to jointly contract and plan strategy due to antitrust restrictions. To avoid collusion concerns, control over appointment and dismissal of the CEO, board members, budgets and material transactions must reside within a single governing board. Although this almost always occurs in change-of-control transactions, these broad powers may be antithetical to the principles underlying a noncontrol transaction, which posit that control will not change. If significant powers are not bestowed upon a single governing board at the larger health system, the parties must avoid joint contracting and implement safeguards and firewalls to ensure that competitively sensitive information is not shared in a manner that would violate the antitrust laws.

For example, a large and small system could implement a noncontrol transaction in which cardiac surgery programs are operated under the control of a single operating board. The two systems might be able to jointly contract and plan strategy with respect to cardiac surgery, but they could not do so on unrelated service lines. They also would need to ensure that they are not directly or inadvertently sharing competitively sensitive information or restricting the other party's competitive activities with respect to unrelated service lines or markets.

For this reason, noncontrol transactions for whole hospitals — in contrast to those involving one or more service lines — more frequently occur when the systems are geographically remote or do not otherwise compete with each other.

Under a Better Brand

Many noncontrol transactions include branding and marketing rights, in which one health system is allowed to use the other's brand to market itself or certain service lines. The license fee can be structured as an annual cash payment, or the licensing health system can receive a membership interest in the smaller system together with a guaranteed annual dividend or distribution. This assumes that both systems are tax-exempt entities. The nonprofit corporation laws of some states also restrict the ability to implement equitylike investments with defined annual dividends.

Although valuing intellectual property can be a difficult exercise, it is important to be accurate. Fees that are inconsistent with fair market value can raise concerns under the Anti-Kickback Statute.

The health system that is licensing its brand also will want to ensure that continuing use of the brand is tied to reasonable and objective conditions of use and quality standards, safeguarding against brand erosion. Both systems must agree upon the manner in which new facilities, physician practices and services lines (i.e., those that do not exist when the noncontrol transaction initially is consummated) may be branded.

Apart from technical use of the brand, a system that licenses its brand may, in some cases, require that the medical staff of a branded service line be closed to physicians who are not credentialed by it. In many cases, the branded service line also will adopt the larger system's protocols and clinical pathways. For a smaller system with an independent medical staff, additional privileging, peer review or operating protocols may require educating the medical staff so that they

understand the rationale and requirements. When permitted by the brandholder, changes can be implemented gradually, helping to ease the transition and allowing time for buy-in from the medical staff.

Spell Out Benefits

Almost all noncontrol transactions involve the implementation of clinical and programmatic enhancements. These enhancements can include implementation and tracking of clinical protocols and pathways, rotations of specialists, clinical consults, medical education, recruiting assistance, research collaborations, electronic health record integration, service line management, revenue cycle support and other collaborative initiatives. When clinical and performance data are collected and tracked, it is common for the larger entity to provide benchmarking data comparing the smaller system's performance with that of its own hospitals.

A common concern of parties to noncontrol transactions is that they have different expectations as to the scope or timing of the support that would be provided. To avoid trouble down the road, clinical integration committees comprising members from both systems can take a lead role in developing clinical and operating integration plans. Where certain activities are critical, the parties can develop a detailed summary of integration plan commitments prior to signing the transaction agreements.

When programmatic enhancements are less critical to ongoing operations, a broad outline can be included in the agreements, and the parties can decide upon a process and timetable to further define their precise responsibilities. This approach recognizes that it may be difficult for the parties to fully define the scope of programmatic enhancements at the outset because some will depend upon the relative successes and failures of the parties in implementing their primary areas of collaboration. When the par-

ties have not fully defined the scope of collaborative activities at the time they sign agreements, both should define a process by which later disputes can be resolved.

The Art of the Unwind

Noncontrol transactions tend to align strategic interests without requiring one of the parties to become fully integrated with the other. In many cases, the transactions are structured to exist for a discrete period, after which the parties can jointly choose to renew the arrangement. As a result, these transactions present unique challenges: The parties must address what happens when the arrangement expires, and what happens if one of the parties exercises its right to terminate the arrangement early because of the other party's failure to perform.

Although noncontrol transactions tend not to integrate operations as much as mergers or acquisitions, many legal, financial and operational issues still must be addressed upon an unwind. Some of the more important questions to answer include:

- How will assets and liabilities of the venture be allocated among the parties?
- Where operations were consolidated, what transition services will be provided by one party to the other while the hitherto consolidated functions are separated? How long will these services be provided and for what cost?
- How will debt be refinanced?
- How will jointly recruited and employed physicians and staff be allocated between the parties?
- When the combined operation holds critical payer or vendor contracts, how will the contracts be allocated or replicated to apply to both parties?
- Will either party be bound by any noncompetition covenants after the unwind of the venture?

The negotiation of the unwind terms is a balancing act. On the one hand, the discussion of unwind rights and

obligations is akin to negotiating the terms of a divorce before the parties have been married. Due to the inherently negative focus of these discussions, they can engender ill will and raise trust issues that can impact the ability of the parties to reach agreement on the terms of the underlying transaction itself.

On the other hand, if the parties do not clearly define unwind triggers and rights, they can find themselves stuck in an untenable business arrangement with no clear exit path other than litigation. Because operations can suffer during the transition period, the goal always should be to complete the unwind as quickly and as cleanly as possible; however, litigation is almost never quick, clean or predictable. Consequently, the art of addressing unwind terms is to find a balance so that there is enough detail to eliminate ambiguities and the risk of litigation, while avoiding the temptation to negotiate every conceivable detail so as to sour the goodwill of the parties and their hopes for the venture.

For Some, a Perfect Fit

Important strategic considerations and material antitrust restrictions impact a decision to enter into a noncontrol transaction, so this type of affiliation is not a panacea for all. However, these transactions can be a viable platform to address a system's needs when more traditional change-of-control transactions are not desirable or possible. As hospitals continue to consolidate, systems will increasingly use noncontrol transactions as a tool to help them meet the challenges of the post-health reform world while retaining their independence. **T**

John Callahan (jcallahan@mwe.com) is a partner and head of International Healthcare Mergers and Acquisitions, and **Stephen Wu** (swu@mwe.com) is a partner in the Antitrust Group, McDermott Will & Emery, Chicago. **Patrick Allen** (pallen@kaufmanhall.com) is senior vice president, Kaufman Hall, Skokie, Ill.