Health Care Mergers and Acquisitions
“The Legal Perspective”

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Today’s Agenda

• Introductory Concepts
  • Trends
  • Case Law Takeaways

• Regulatory Compliance
  • Stark Law Concepts
  • Antitrust Concepts

• St. Luke’s Health System
  • Antitrust Case Overview

• Practical Takeaways
Health Care Reform - Trends

- Health exchanges
- Improved population management
- Payment models focusing on value, not volume
- Bundled payments
- Expansion of Medicaid coverage
- Innovative care delivery models
- Integration, accountability and risk sharing
- Emphasis on prevention and wellness
- Market consolidation
Hospital Industry Consolidation

- Economic pressures and uncertainty are driving an increase in provider mergers and acquisitions and other affiliation arrangements.

### Hospitals Involved in Mergers and Acquisitions

<table>
<thead>
<tr>
<th>Year</th>
<th>Deals</th>
<th>Average Beds Per Deal</th>
<th>Median Price Per Bed</th>
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</thead>
<tbody>
<tr>
<td>2007</td>
<td>58</td>
<td>386</td>
<td>$237K</td>
</tr>
<tr>
<td>2008</td>
<td>60</td>
<td>88</td>
<td>$166K</td>
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<tr>
<td>2009</td>
<td>42</td>
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<td>300</td>
<td>$401K</td>
</tr>
<tr>
<td>2012</td>
<td>78</td>
<td>233</td>
<td>$312K</td>
</tr>
<tr>
<td>2013</td>
<td>54</td>
<td>838</td>
<td>$417K</td>
</tr>
</tbody>
</table>

Source: Irving Levin Associates, Inc.

### 2014 Largest Not-for-Profit Health Systems

<table>
<thead>
<tr>
<th>Health System</th>
<th>Number of Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ascension Health</td>
<td>73</td>
</tr>
<tr>
<td>CHE/Trinity Health</td>
<td>45</td>
</tr>
<tr>
<td>Adventist Health System</td>
<td>36</td>
</tr>
<tr>
<td>Kaiser Permanente</td>
<td>36</td>
</tr>
<tr>
<td>Dignity Health</td>
<td>34</td>
</tr>
<tr>
<td>Catholic Health Initiatives</td>
<td>32</td>
</tr>
<tr>
<td>Sutter Health</td>
<td>26</td>
</tr>
<tr>
<td>Providence Health &amp; Services</td>
<td>26</td>
</tr>
</tbody>
</table>

Hospital - Physician Alignment

• Physicians are increasingly leaving independent practices to become employed by hospitals and health systems.

Growing Trend

• Newly trained physicians see health systems as a “safe haven” from uncertainty.
• Health systems see primary care as a necessary investment to lock in future business.
• Smaller multispecialty groups are dissolving as select specialties pursue hospital employment to improve compensation levels.

Source: Adapting to a new model of physician employment. Accenture.
Health Care Market: Perfect Storm

- **Increases in transactions and consolidation**
  - More financial relationships with referring physicians
  - More consolidation in concentrated markets

- **A complex and highly technical regulatory environment**
  - Stark Law Compliance
  - Antitrust Compliance

- **Aggressive enforcement and disproportionate penalties**

- **Transactions must be defensible under applicable laws**
  - 3 Tenets of Compliance (FMV, CR and not TIA Referrals)
  - Must have defensible business models and structures
  - Must have a defensible business justification

- **Process and documentation should support defensibility**
Stark Concepts: 3 Tenets of Compliance

• The Toumey Case
  - FMV
  - CR
  - TIA
  
  a. entered into compensation arrangements with physicians in violation of the Stark Statute, specifically by paying the physicians (who referred designated health services) under contracts that exceeded fair market value, were not commercially reasonable and which took into account the volume or value of the referrals or other business generated between the physician and Tuomey;

• The Halifax Case
  - FMV
  - CR
  - TIA
  
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67. On April 28, 2008, for example, the Finance Committee of the Board met to approve the purchase of EMA and employment of Drs. Bradley, Corse, and Gaskin. Sharon Bell and Hart Williford, a former Chief Operating Officer and Senior Vice President of the Parent Company, prepared a PowerPoint Presentation to the Finance Committee in support of the addition of EMA (the “April 28 PowerPoint”), which was attached to the minutes of the meeting.

a. On a slide titled “Background Information,” the April 28 PowerPoint notes that Drs. Bradley, Corse, and Gaskin are the “three busiest members of the Candler Medical Group” and EMA is a “high-volume practice with large numbers of hospital admission and referrals to specialists.”

b. The next slide, also titled “Background Information,” stated that “estimated gross revenues (including downstream revenues from referrals) to St J/C” are for 2006: “$57 million + $3.4 million radiology”

2007: “$63 million + $3.7 million radiology”

c. The slide indicated that the information was “reported by physician,” and that these figures “account[] for almost 6% of St J/C total volume.”
In his Report, Mr. Day notes that the Board of BRMC wanted a covenant not to compete associated with the sublease in order to protect “three revenue streams”: CT and MRI revenues, inpatient net revenues, and outpatient net revenues (not including CT and MRI revenues). (Day Report, at 14.) In his appraisal of the covenant not to compete, Mr. Day created a table to show the expected revenues BRMC would receive with the non-competition agreement in place, and compared those revenues to how much BRMC would pay under the non-compete agreement. (Id. at 17.) Mr. Day explained that his table is “based on the assumption that the Physicians would likely refer this business to the Hospital in the absence of a financial interest in their own facilities or services, although they are not required to do so by virtue of any of the covenants contained in the Agreements or otherwise.” (Id.)

Therefore, the Report itself indicates that the analysis of whether the non-competition agreement represents a fair market value is based, in part, on anticipated referrals from the doctors. BRMC affirmed that the Report evaluated expected revenues based on the assumption that Defendants would likely refer the business to BRMC. (Leonhardt Dep. at 56.)
Infirmary: Need Defensible Structure

c. Defendants Ignored Specific Warnings and Discussions about Stark Law Compliance Requirements

109. Throughout the relevant time period, Defendants were aware that they had to comply with the Stark Law and Anti-Kickback Statute, but took no affirmative steps to ensure their compliance. In fact, Defendants ignored specific warnings that their distributions of DHS collections to DPG did not comply with these laws and regulations.

110. On June 28, 2010, Defendants specifically discussed Stark Law compliance at IMC-DMC and IMC-Northside. At a meeting attended by Sanders, DPG executives, and IMC/IMC-DMC employees, Sanders summarized findings from DPG’s counsel: “[Attorney] Horton’s opinion – CMS would likely rule that because 2 entities exist we do not meet the strict definition of a ‘Group Practice’ and the IOAS exception was not available.”
reasonable. First, the purchase of TCTC was not commercially reasonable because the purchase was designed not to meet a commercially reasonable need (such as additional capacity or needed new equipment) but to insure that no competitors to JBACC/CRHS entered the market for radiation oncology therapy services. Second, the purchase price did not reflect fair market value, but reflected the price CRHS believed it would have to pay to keep competitors out of the market for TCTC. In fact, as the Defendants determined in December 2012 after Dr. Tidwell retired, the equipment they purchased was essentially worthless. The purpose of CRHS’ purchase of TCTC was to secure referrals from TCTC to CRHS instead of to its competitors. If any one purpose of a remuneration relationship is to secure referrals, the AKS and Stark Law have been violated.
Penalties: Risk Management Strategies

The court has found that a reasonable jury could conclude the existence of 21,730 false claims. The court is not inclined to overturn the jury’s determination. Tuomey’s argument is without merit. The Government’s motion for entry of judgment under the FCA (ECF No. 818) is granted.

IV. CONCLUSION

For the reasons stated herein and appearing in the record, the Clerk of Court shall enter judgment on the jury verdict of $39,313,065.00. The Clerk of Court further shall enter judgment under the FCA in the amount of $237,454,195.00.

IT IS SO ORDERED.

/s/ Margaret B. Seymour
Senior United States District Judge
St. Luke’s: Consider Antitrust Risks

divisions, parents, subsidiaries, affiliates, partnerships, or joint ventures, permanently enjoining their merger, acquisition, or consolidation pursuant to certain Agreements entered on or about December 24, 2012, in violation of Section 7 of the Clayton Act, 15 U.S.C. § 18, and Idaho Code Section 48-106 of the Idaho Competition Act. In support of this Complaint, Plaintiffs allege as follows:

I.

NATURE OF THE CASE

1. St. Luke’s acquisition of Saltzer (the “Acquisition”) will substantially lessen competition for healthcare services in and around Nampa, Idaho. The Acquisition gives St. Luke’s a dominant market share of adult primary care physician services (“Adult PCP Services”) sold to commercial health plans and provided to Nampa-area residents. The high level of concentration in this market resulting from the Acquisition creates a strong presumption of anticompetitive harm under the U.S. Department of Justice and Federal Trade Commission Horizontal Merger Guidelines (“Merger Guidelines”). Beyond that presumption, quantitative
NOW THEREFORE IT IS HEREBY ORDERED, ADJUDGED, AND DECREE, that St Luke’s acquisition of the Saltzer Medical Group violates § 7 of the Clayton Act and the Idaho Competition Act.

IT IS FURTHER ORDERED, ADJUDGED, AND DECREE, that St. Luke’s is permanently enjoined from acquiring the Saltzer Medical Group, and that St. Luke’s shall fully divest itself of Saltzer’s physicians and assets and take any further action needed to unwind the Acquisition. The Clerk is directed to close this case.
Regulatory Framework

• Federal Health Care Programs
  — Anti-Kickback Statute
  — Federal Stark Law
  — False Claims Act
  — Civil Monetary Penalties Law

• Tax Exemption Issues
  — Private Benefit, Inurement and Intermediate Sanctions

• Antitrust Compliance
  — Clayton Act

• State Law Issues
  — Corporate practice of medicine, employment, etc.
Stark Regulatory Framework

• If Physician + Financial Relationship + Entity:
  – Physician **may not make a Referral** to that Entity for the furnishing of Designated Health Services ("DHS") for which payment may be made under Medicare; and
  – The entity **may not bill Medicare**, an individual or another payor for the DHS performed pursuant to the prohibited Referral...

  ... unless the arrangement fits squarely within a Stark exception

• Threshold Compliance Statute
  – Strict liability – no intent required. Civil (non-criminal statute)
  – Triggered by “technical” violations, inadvertence and error
  – Your regulatory “Litmus Test”
  – 11 Categories of DHS (e.g., clinical lab services, radiology and certain other imaging services, radiation therapy and supplies, outpatient prescription drugs, inpatient and outpatient hospital services, etc.)
Potential Stark Transaction Models

• Common Stark Exceptions:
  – Rental of Office Space or Equipment
  – Physician Recruitment
  – Personal Service and FMV Exceptions
  – Isolated Transactions
  – Bona Fide Employment
  – In-Office Ancillary Services

• Common Elements of the Stark Exceptions:
  – Signed, written agreement that specifies the services or property
  – Arrangement must be CR, and compensation must be consistent with FMV
  – Compensation must be set in advance and not TIA the volume or value of referrals generated between the parties
Stark Risks: Financial Projections

- Examining anticipated referrals creates higher legal risk,
- Risk may be mitigated by:
  - separating physician negotiations and financial arrangements from projections data;
  - attempting to use aggregated data rather than physician-specific data;
  - limiting the use of downstream data and the individuals involved;
  - explicitly stating that the remuneration does not TIA referrals;
  - communicating the proper purposes of an arrangement in all planning and executed documents;
  - educating the correct personnel regarding this area of legal risk;
  - using a valuation consultant to confirm FMV and CR.
Flexibility for “Stark Group Practices”

- Physicians in a group practice may be paid:
  - a share of the overall profits of the group;
  - a productivity bonus based on services that he or she has personally performed, or services “incident to” such personally performed services, or both;
- Cannot be determined in any manner that is directly related to the volume or value of referrals of DHS by the physician; and
- Must meet “incident-to” billing requirements
Hyper-Technical Requirements

- **Single Legal Entity Test.** Must be a “single legal entity” operated primarily for the purpose of being a group practice (e.g., a hospital cannot be a group practice, etc.).

- **Physicians.** 2 physicians must be owners or employees of the group practice (i.e., not independent contractors).

- **Unified Business Test.** A body representative of the group practice must maintain “effective control” over its assets and liabilities.

- **Distributions of Income and Expenses.** Methods of distribution must be determined by the group practice prospectively before the receipt of payment for services.

- **Range of Care.** Each physician must furnish substantially his or her full range of patient care services through the group practice.

- **“Substantially All” Test.** At least 75% of the aggregate total patient care services of the group practice members must be furnished and billed through the group.

- **Physician-Patient Encounters.** Members of the group (i.e., not independent contractors), in the aggregate, must personally conduct no less than 75% of the physician-patient encounters of the group practice.

- **Volume/Value Compensation Test.** Shares of overall profits and productivity bonuses cannot be determined in a manner that directly relates to the volume or value of a physician’s referrals of DHS.
Documenting Stark Compliance - Roles

• Role of the Valuator
  – Recommends final transaction valuation parameters and provides expertise on compensation matters
  – Issues an *objective* third-party opinion on FMV and CR

• Role of Legal Counsel
  – Manages the transaction and valuation process within the a/c privilege
  – Assists with structuring the transaction and due diligence
  – Assist client with negotiating and drafting the definitive agreements
  – Carefully examines the valuator’s opinion to enhance defensibility
  – Does not to opine on FMV and CR
Stark Enforcement Action Takeaways

• Focus on physician compensation arrangements
  – Compensation allegedly not FMV and CR
  – Technical issues with team-based and bonus methodologies
  – Testing of the underlying “group practice” requirements

• Increases in enforcement
  – Tuomey Healthcare – South Carolina ($237.5 million judgment)
  – Infirmary Health System – Alabama (2014 – $25 million)
  – Halifax Hospital – Florida (2014 – $85 million)
  – New York Heart Center – (2014 – $1.3 million)
Key Antitrust Concepts

• Transactions that create or enhance market power may raise anti-competitive concerns
• Horizontal mergers are higher risk than vertical mergers
• Antitrust analysis is a highly fact-specific, economics-based analysis
• Antitrust laws are enforced by the FTC, DOJ, state AGs, but private actions are also available
Antitrust Framework

• Key Statute: Section 7 of the Clayton Act
  – Prohibits transactions whose effect substantially lessen competition
  – Requires premerger (HSR) reporting and waiting periods for transactions meeting certain financial thresholds

• Horizontal Merger Guidelines (FTC/DOJ)
  – Key question: Will the merger likely result in anti-competitive effects?
  – Actual effects of consummated mergers
  – Market shares and concentration
  – Intensity of head-to-head competition
St. Luke’s Antitrust Case: Overview

• Largest health system in Idaho bought largest independent physician group in Idaho
• Both employed primary care physicians in Nampa, Idaho. Together, had an 80% combined share of the Nampa market
• The transaction was challenged by the FTC, Idaho AG and private hospitals
• Witnesses against the transaction included payors and employers
• The primary defense was that the transaction would allow St. Luke’s to achieve the goals of health care reform
• The court held that the transaction would have anti-competitive effects in the market for adult primary care physician services and ordered divestiture
Nampa and the Treasure Valley
Market Before the Acquisition

- Before the Acquisition: Saltzer PCPs offer an attractive substitute for St. Luke’s PCPs, and vice versa
  - The health plan thus has a credible “outside option” when it negotiates with each provider
Market After the Acquisition

After the Acquisition: the health plan loses a credible outside option, and the provider gains negotiating leverage.

- St. Luke’s & Saltzer
- Health Plan
- Saint Al’s
- Others
- Entrants?
Antitrust Defense Theories

• The geographic market was broader than Nampa
• The transaction was unlikely to have horizontal anti-competitive effects
• The transaction would create efficiencies that would outweigh any anti-competitive effects
  – Population health management, integrated and coordinated care
  – Movement to a risk-based, value-based care delivery system
• Other providers would enter into the market
The Court’s Decision

- Only addressed the adult primary care physician market
- The relevant geographic market was Nampa
- The transaction would increase bargaining leverage with health plans, and would increase reimbursement rates that would be passed on to consumers through higher premiums
- The transaction would increase prices because more services would be provider-based
- Any efficiencies were not merger-specific
- The transaction’s effect would be “to substantially lessen competition” making it unlawful under the Clayton Act and Idaho Competition Act
- The only appropriate remedy was divestiture
The antitrust laws essentially require the Court to predict whether the deal under scrutiny will have anticompétitive effects. The Court predicts that it will. Although possibly not the intended goal of the Acquisition, it appears highly likely that health care costs will rise as the combined entity obtains a dominant market position that will enable it to (1) negotiate higher reimbursement rates from health insurance plans that will be passed on to the consumer, and (2) raise rates for ancillary services (like x-rays) to the higher hospital-billing rates.
The antitrust laws essentially require the Court to predict whether the deal under scrutiny will have anticompetitive effects. The Court predicts that it will. Although possibly not the intended goal of the Acquisition, it appears highly likely that health care costs will rise as the combined entity obtains a dominant market position that will enable it to (1) negotiate higher reimbursement rates from health insurance plans that will be passed on to the consumer, and (2) raise rates for ancillary services (like x-rays) to the higher hospital-billing rates.
The Acquisition was intended by St. Luke’s and Saltzer primarily to improve patient outcomes. The Court is convinced that it would have that effect if left intact, and St. Luke’s is to be applauded for its efforts to improve the delivery of health care in the Treasure Valley. But there are other ways to achieve the same effect that do not run afoul of the antitrust laws and do not run such a risk of increased costs. For all of these reasons, the Acquisition must be unwound.
Health Care M&A Practical Takeways

• We are seeing an increased in health care transactions and consolidation

• Transactions must be defensible
  – Must comply with the Stark and Antitrust Laws
  – Consider the 3 Tenets of Compliance (FMV, CR and not TIA Referrals)
  – Must have defensible business models and structure
  – Must have a defensible business justification

• Processes and documentation should support defensibility
For additional information about Hall Render and to view our educational articles on a variety of health law topics, please visit our website at www.hallrender.com/resources.

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