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New Healthcare “M&A” Developments

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Health lawyers advising their clients on provider merger/acquisition activity should be aware of a series of new legal developments with potential implications in structuring specific transactions. These developments include the May 21 charitable trust-based decision of the New Hampshire Attorney General opposing the controversial CMC Healthcare/Dartmouth Hitchcock proposed merger; the Colorado Attorney General’s May 25 analysis of the application of state law to a proposed municipal hospital transaction; additional evidence of state charity official intervention in the transaction process; and increased hospital merger antitrust enforcement.

The legal significance of these and similar developments is enhanced by the notable increase in provider merger and acquisition activity, principally in reaction to the forces of healthcare reform and realignment. As Moody’s Investor’s Services noted in a recent “Special Comment” to its clients, there is a clear trend towards increased competition and consolidation in many hospital/provider markets, making consolidation more attractive to both potential acquirers and possible targets. Moody’s cites as an additional contributing factor the availability of for-profit partners capable of contributing in such transactions needed capital for modernization and expansion.[\[1\]](#)

The principal message of the developments discussed below is that merger/acquisition transactions are by their nature highly complex, triggering unique legal issues not typically present in more traditional health industry transactions and arrangements. Healthcare lawyers advising their clients in these kinds of transactions may well wish to anticipate addressing a broad array of legal issues, including the following:

1. *Charitable Trust Barriers.* The May 21, 2010 decision of the New Hampshire Attorney General to oppose the proposed combination between CMC Healthcare System (CMC) and Dartmouth Hitchcock Health (DHH) serves as an example of how charitable trust laws can

apply to transactions involving nonprofit corporations, depending upon applicable state law.^[2] CMC and DHH had entered into an agreement by which the parties would combine, with CMC and its affiliates becoming subject to the control of DHH as part of the DHH healthcare delivery system. The Attorney General reviewed the proposed transaction consistent with specific state law governing the transfer of control of healthcare charitable trusts, and with its general common law authority.

The Attorney General's Report described the transaction as involving the creation of a regional integrated delivery system including an academic medical center and hospital (in Lebanon, NH), an acute care hospital (in Manchester, NH), and a multi-specialty physician clinic (also in Manchester). According to the Attorney General, the governance structure of the system would be arranged such that DHH would be the controlling entity. From the Attorney General's perspective, the transaction represented an affiliation between a religiously sponsored nonprofit healthcare system (CMC) and a secular nonprofit healthcare system, both of which were charitable trusts under New Hampshire law. The Attorney General's interpretation was that while the transaction agreement established certain safeguards to protect the CMC charitable, religious mission (as well as the DHH mission), the essence of the transaction called for the secular healthcare charitable trusts (DHH) to assume control of the religious health-care charitable trusts (CMC)—which previously have operated as an independent Catholic hospital.

Principally for that reason, the Attorney General opposed the transaction, on the grounds that the proposed change of control "will result in a profound change in the governance structure of [CMC] and diminish the fiduciary duties of the Boards of Directors of the [CMC charities] which will inhibit the ability of the [CMC charities] to carry out their charitable missions."^[3] Notably, the Attorney General was not persuaded by the many guidelines the parties had proposed to protect the respective charitable interests and purposes. Given that, Probate Court approval of the proposed affiliation is required in order for the transaction to be approved under New Hampshire law. Other, lesser objections of the Attorney General included those related to (a) the failure of the parties to provide the Attorney General with enough information from which it could determine the effect of the transaction on the cost of delivering healthcare, as is required to be done by state law; and (b) the failure of the transaction documents to include sufficient safeguards to prevent the calculation of what is referred to in the documents as a "Post-Affiliation Surplus" is not subject to manipulation or abuse by the parties. The Attorney General also expressed criticism of the executive compensation of CMC's CEO, while noting that actual review and approval of the compensation arrangement was outside the scope of the transaction review statute.

The Attorney General's Report, and its decision to oppose the transaction, are the byproducts of its interpretation of a specific state transaction review law, and its

perspective that the contracting hospitals were charitable trusts as well as nonprofit corporations. Those specific factors are not in place in every state. Nevertheless, the detailed and well crafted Report serves as a reminder that in some states, the potential application of charitable trust laws can become a significant legal feasibility factor in a healthcare affiliation transaction—even one involving only nonprofit parties. Health lawyers thus should be sensitive to transaction structures that could be interpreted by state officials as inhibiting the ability of one of the nonprofit parties to carry out its traditional charitable purpose and the related potential need for judicial approval of such a transaction.

2. Municipal Hospital Conversions. In the current economic environment, many municipalities are giving consideration to the privatization of hospitals either owned directly, or through some affiliated nonprofit or governmental entity, by the municipality or other agency of government. These types of transactions are historically complex because of the connection to governmental ownership and control, the possible application of multiple different types of state laws and regulations relevant to the ability to transfer control of the hospital, and potentially differing approaches to the application of any proceeds from the transfer of control of the former municipal/governmental hospital. It is in that context that the Colorado Attorney General’s May 25 analysis of the proposed transfer of ownership of Memorial Hospital, in Colorado Springs, is relevant.[\[4\]](#)

The principal issue under consideration was whether the proceeds from any sale of Memorial Hospital would have to be transferred to a nonprofit, charitable organization with purposes similar (e.g., for healthcare) to those of the hospital. Colorado law includes a “Hospital Transfer Act,” which regulates nonprofit hospital conversions and which requires in essence that the proceeds from any conversion transaction be distributed to one or more nonprofit, charitable, tax-exempt organizations. In this case, the Attorney General reviewed the organizational history of Memorial Hospital, noting in particular that it received Internal Revenue Code 501(c)(3) status from the Internal Revenue Service, and the fact that the Transfer Act encompasses all hospitals, classifies them as either nonprofit or for-profit, and that of course Memorial could not fairly be considered for-profit. Accordingly, the Attorney General determined that Memorial must be considered a nonprofit hospital for purposes of the Act. The principal implications of that determination are two-fold: first, that any transaction involving the Hospital and a for-profit party would be subject to a higher level of scrutiny under the Act; and second—and more significantly—all proceeds from a sale or transfer to a for-profit party must be transferred to a charitable entity with a health care purpose, and thus are not available to the municipality to address broader economic uses. Such an analysis could limit the viability of for-profit proposals to acquire Memorial. However, the Attorney General indicated that

it would support an effort by Memorial to seek a declaratory judgment from the District Court clarifying whether the Act applies to this situation.

The analysis of the Attorney General is thus an important reminder of the potential complexities involved in structuring transactions involving hospitals owned or controlled by units of government.

3. *Charity Official Intervention.* The authors have direct knowledge and involvement in at least five separate M&A transactions taking place this year, where the attorney general's office or other state charity official has intervened in the transaction process to address specific nonprofit law issues. In each instance, the transaction was occurring in a jurisdiction in which there was no formal state transaction approval process (e.g., a conversion statute), apart from perhaps some form of separate certificate of need/exemption approval process.

Generally speaking in these instances, the attorney general's office intervened to address issues relating to two principal areas of concern: *First*, the process by which the board reviewed and approved the transaction (including the level of diligence applied by the board in reviewing management's proposal, the process applied by the board to identify possible transaction partners, and the extent to which it resolved potential board and officer-level conflicts of interest arising in connection with the transaction); and *Second*, the extent to which the reasonableness of the transaction terms and conditions (e.g., consideration paid or received) was determined by the nonprofit organization's board and verified with the support of outside valuation/investment banker experts. In each of these instances, the attorney general/state charity official requested voluminous documents and records in connection with its consideration of the specific transaction. In most instances, the state requested that the nonprofit organization not consummate the transaction absent state authorization. While all of these referenced transactions involved a nonprofit organization proposing to contract with a for-profit organization, it should not be assumed that the attorney general would not have an interest with respect to a transaction between nonprofits should similar issues arise.

4. *Antitrust Enforcement.* In a speech^[5] for the American Bar Association/American Health Lawyers Association Antitrust in Healthcare Conference in late May, Christine Varney, the top antitrust enforcement official for the Department of Justice (DOJ), stated that health reform makes effective antitrust policy more important than ever. She said the role of antitrust is to ensure that competition is preserved and protected, so that the power of competition can be harnessed to expand coverage, improve quality, and control the cost of healthcare.

Achieving cost and quality efficiencies is often the very impetus for two hospitals to a potential affiliation. As the DOJ and Federal Trade Commission (FTC) recognize in their proposed Revised Horizontal Merger Guidelines issued on April 20 (Merger Guidelines),^[6] a primary benefit of mergers is their potential to generate significant efficiencies and enhance the merged hospitals' ability and incentive to compete, which may result in lower prices, improved quality, or enhanced service. In analyzing efficiencies identified by hospitals to a proposed transaction with competitive implications, the DOJ and FTC consider whether the efficiencies likely would be sufficient to reverse the transaction's potential to harm patients, e.g., by preventing price increases.

Health lawyers advising parties to a proposed transaction with competitive implications should be mindful of the importance of identifying and quantifying cognizable efficiencies. Health lawyers should also consider whether a merger is necessary to realize those efficiencies—or whether there is some less restrictive means such as a limited purpose joint venture—to achieve them.

Finally, health lawyers should be mindful of new tools—such as merger simulation models—that the FTC is using to analyze likely price effects of hospital mergers. These models focus on substitutability of competing hospitals, rather than on market concentration. The FTC's use of this new tool is consistent with the change in emphasis under the revised Merger Guidelines from market definition to competitive effects. Although the FTC has stated that merger simulation modeling is one tool they now use in hospital mergers and that the results of this analysis are not dispositive, it will be important for health lawyers to work with economists to address these models in their economic review of transactions with competitive implications.

As the pace of healthcare merger/acquisition activity increases, health lawyers will want to monitor new developments such as these, for their application to specific transaction proposals.

^[1] Moody's Investors Service, Special Comment: "For Profit Investment in Not-for-Profit Hospitals Signals More Consolidation Ahead," April 20, 2010.

^[2] See New Hampshire Department of Justice, Office of the Attorney General, "Report of the Director of Charitable Trusts Regarding the Proposed Acquisition Transaction Between CMC Healthcare System and Dartmouth-Hitchcock Health" (Report), May 21, 2010, available at http://doj.nh.gov/publications/documents/cmc_dhh_rpt_exh.pdf.

^[3] *Id.* at p. 2.

[4] "Attorney General Analysis of the Application of the Hospital transfer Act to Memorial Hospital, John Suthers, Attorney General," available at <http://csbj.com/wp-files/hosted-pdfs/hta.pdf>.

[5] "Antitrust and Healthcare," Remarks as Prepared for the ABA/AHLA Antitrust in Healthcare Conference, May 24, 2010, *available at* <http://www.justice.gov/atr/public/speeches/258898.htm>.

[6] *Available at* <http://www.ftc.gov/os/2010/04/100420hmg.pdf>.

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