BoardRoom Press

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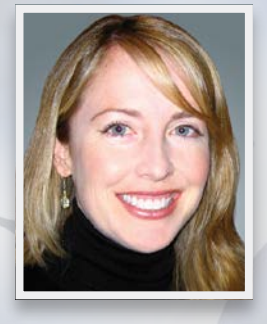
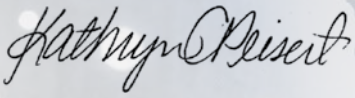


All of us who have taken part in the healthcare system as patients and family members of patients have experienced confusion about how insurance works, what it covers, and what our final bill(s) will look like. It's a nuisance we would all choose to avoid if we could, and many do to the detriment of their health and their costs of care. With the expansion of Medicaid and enrollment in the Healthcare Marketplace exchanges, more patients will benefit from having insurance but those same patients will experience this confusion as well. How does this fit into our view of patient-centered care?

In this issue, Barbara Lyons of the Kaiser Family Foundation describes the work yet to be done in expanding insurance coverage for Americans, as well as our responsibility to help those newly insured navigate the complicated system. HFMA's Joe Fifer argues that the patient's financial experience while in the healthcare system should be considered part of the overall patient satisfaction experience, and therefore, board members have a direct responsibility to ensure the organization is assisting patients in understanding and preparing for what their financial experience will be. Research shows that patients avoid receiving necessary care if they are concerned about the cost. This lowers the likelihood of positive patient outcomes and prevents providers from being able to treat patients at the right time, before complications arise and costs increase. From a population health perspective, this can have consequences if the patient is counted in a risk-based, shared savings, or bundled payment contract. From a consumer perspective, this is a ripe opportunity for hospitals and health systems to build trust with patients by recognizing the importance of a positive financial experience and helping the patient navigate the cost maze.



Kathryn C. Peisert *Managing Editor*

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The ACA Coverage Expansions: Where Are We and What's Ahead?

BY BARBARA LYONS, KAISER FAMILY FOUNDATION

As we enter the third year of open enrollment, dramatic coverage gains have been achieved under the Affordable Care Act (ACA). Millions of Americans have been covered through new Health Insurance Marketplaces, Medicaid, and private insurance. The uninsured rate has dropped to the lowest rate in decades and expanded coverage has led to improved access to care. Looking ahead, reaching the remaining uninsured and ensuring that coverage translates to care and is affordable remain priorities.

Barbara Lyons
Senior Vice President
Kaiser Family Foundation

The ACA Increased Access to Coverage for Millions of Uninsured Americans

The enactment of the ACA in 2010 ushered in far-reaching changes to the U.S. healthcare system and broadened access to health coverage by building on employer-based coverage, restructuring the individual insurance market, establishing Health Insurance Marketplaces, and increasing access to affordable coverage for low- and moderate-income Americans by expanding Medicaid and offering tax subsidies for the purchase of private insurance. The ACA provides federal tax credits for people with incomes from 100 to 400 percent of the federal poverty level (FPL) ($19,790 to $79,160 for a family of three) to use to purchase coverage. For the low-income population, the ACA fills historical gaps in Medicaid eligibility by extending Medicaid to nearly all non-elderly adults with incomes at or below 138 percent of the FPL ($27,724 for a family of three). With the June 2012 Supreme Court ruling, the Medicaid expansion essentially became optional for states, and currently, 30 states and Washington, D.C. have expanded Medicaid eligibility under the ACA.

Marketplace and Medicaid Enrollment Gains

In 2014, the major coverage provisions of the ACA were implemented, resulting in millions of Americans gaining coverage. Approximately 10 million individuals are enrolled in state or federal Marketplace plans. Most Marketplace enrollees (84 percent) receive premium subsidies and over half (56 percent) also receive cost-sharing subsidies to help afford coverage.[1] Medicaid enrollment has also grown by 14 million since the period before the first open enrollment, which started in October 2013, with gains particularly strong in states that adopted the Medicaid expansion. Further facilitating coverage, all states have modernized Medicaid enrollment processes under the ACA and coordinated with Health Insurance Marketplaces, although work to fully realize streamlined enrollment and renewal continues.

Marketplace and Medicaid enrollment gains do not appear to have resulted in an overall decline in employer-based coverage, the mainstay of coverage in the U.S. Steady during the past two years, over half of firms offer health benefits to employees, and most workers at these firms are eligible for health benefits and take up coverage. The vast majority of adults who have gained coverage since the ACA coverage expansions began have low or moderate family income in the range targeted for financial assistance under the ACA and most are in working families. Despite concerns about adverse selection into coverage, about half of newly insured adults are under age 35 and newly insured adults are in better health than those who remained uninsured.

Strides in Reducing the Uninsured

Enrollment in ACA coverage has resulted in large declines in the uninsured rate. The number of uninsured non-elderly Americans in 2014 was 32 million, an unprecedented decrease of nearly nine million people since 2013. Declines have continued into 2015 with the uninsured rate down to 10.5 percent in the second quarter from 16.6 percent in 2013,[2] with significant declines for non-elderly adults. Uninsured rates for children also improved but are much lower than adults due to children's higher eligibility levels for public coverage. Coverage gains have been particularly large among low-income individuals and people of color—groups that had high uninsured rates prior to 2014. Medicaid expansion states saw steep reductions in the uninsured rate from 14.9 percent in 2013 to 8.5 percent in the second quarter of 2015.[3] Non-expansion states also saw somewhat smaller declines, as low- and moderate-income people enrolled through the Marketplace, and Medicaid eligible uninsured adults and children enrolled as a result of expanded outreach and improved enrollment processes. Enrollment growth has been facilitated by Marketplace assisters

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Key Board Takeaways

The ACA has increased access to health coverage for millions of Americans, led to improved access to care for newly insured people, and resulted in fewer individuals and families facing the health and financial consequences of not having insurance. Still millions of people remain uninsured and newly insured individuals may not be familiar with how insurance coverage works or how to navigate the healthcare system. With the third open enrollment period upon us, healthcare leaders have a key role to play in mobilizing outreach efforts to hard-to-reach populations and promoting strategies to facilitate timely and affordable access to healthcare services. Key priorities include:

- Getting the word out about coverage opportunities and how to sign up utilizing local healthcare providers, grassroots organizations, the media, and assisters
- Supporting efforts aimed at increasing "health literacy," particularly among newly insured consumers to help people understand and make the best coverage and plan choices, in terms of affordability and access to providers
- Organizing providers and delivery systems to reach beyond the walls of the hospital to community settings to facilitate patient access to preventive services, primary care, and management of chronic health conditions
- Convening community leaders to discuss strategies to keep people covered and eliminate gaps for the remaining uninsured

1 The Kaiser Family Foundation State Health Facts, Total Marketplace Enrollment and Financial Assistance (available at http://kaiserf.am/1QxVzra).

2 Michael E. Martinez and Robin A. Cohen, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–June 2015*, Centers for Disease Control and Prevention, National Center for Health Statistics, November 2015.

3 Martinez and Cohen, November 2015.

The Role of Financial Communication in Building Community Trust: What Board Members Need to Know

BY JOSEPH J. FIFER, FHFMA, CPA, HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

Increased consumer cost-sharing and the trend toward consumerism that is sweeping through healthcare are raising consumers' awareness and changing their expectations about the way they are treated with regard to billing and payment as well as their clinical care.

Although price transparency often garners the lion's share of media attention when it comes to financial matters, transparency is only one piece of the financial cycle. That cycle, which starts when consumers first contemplate a healthcare encounter and ends when their financial responsibility for that encounter is fully resolved, has many touch points.

An individual's experiences throughout the financial cycle can influence not only the payment received by the hospital or health system but also the person's attitude toward the organization and even toward healthcare in general. Through word of mouth and social media, negative financial experiences can become dissatisfiers that erode the community trust hospitals have worked so hard to build.

It's time to consider the patient's financial experience as part of the overall patient experience package. The following five guidelines, which have been distilled from industry consensus-based best practices, are designed to help board members guide their organizations toward better financial experiences for patients and better outcomes for both the patient and the hospital.[1]

Guidelines for Improving the Customer's Financial Experience

Build the financial experience around respect for patients. In Eric Topol's book, *The Patient Will See You Now,* he points out that patients are the Rodney Dangerfields of medicine.[2] In other words, patients "don't get no respect." The good news is that the balance of power is changing. Driven by a generational shift and changing physician/patient dynamics, providers are increasingly looking for ways to treat patients as true partners in their healthcare. Providers who realize that patient engagement is crucial to success in the new era of consumerism care will embrace this culture change. In the financial cycle, there are many small but significant opportunities to demonstrate respect for patients. These include coordinating efforts to avoid asking patients for basic demographic and insurance information multiple times, ensuring privacy when financial matters are discussed, and offering patients the option to have family members, a patient advocate, or a translator present during a financial conversation.

Prevent financial toxicity. Two years ago, Peter Ubel, M.D., and two other physicians coined the term "financial toxicity" to describe the impact of unaffordable bills on a patient's health.[3] Although discussions of financial toxicity are usually related to cancer treatment, the concept has broader applications, especially as it pertains to surprise bills, which have become a frequent media target. Surprise bills run the gamut from unexpected fees (such as facility fees) to bills from physicians who were only tangentially involved in a patient's care to out-of-network charges that are incurred even when the patient is using an in-network hospital. Although surprise bills are a multifaceted problem with no silver-bullet solution, upfront communication can go a long way toward preventing them. For example, hospitals, physicians, and health plans should each alert consumers about the risk of out-of-network bills and provide them with the information they need to reduce their risk of being billed for inadvertent out-of-network usage.

Elevate the role of the frontline staff who create financial experiences for patients. The role of patient access staff has gone far beyond the clerical functions of conducting transactions and processing paperwork. Patient access staff are now routinely expected to educate patients who don't understand basic insurance terminology, let alone their individual cost-sharing responsibilities, and to deal with patients who are anxious about their ability to pay for services and frustrated with the healthcare system in general. Often, the only formal preparation that patient access staff receive is on-the-job training. That training should include communication and customer service skills in addition to hospital policies and procedures. In many ways, patient access staff serve as the hospital gatekeepers. Appropriate training will equip them for their growing responsibilities and help ensure positive experiences and outcomes for patients.

Recognize that the financial experience continues after patients leave the hospital. As cost-sharing has increased, patients are responsible for a greater portion of their healthcare costs, which sometimes results in medical bills going unpaid. The burden of medical debt has captured the attention of consumer advocates, the media, regulators, and the Consumer Financial Protection Bureau. Respect and concern for patients must extend to the last stage of the financial cycle: resolution of the bill. This has many implications, in practice. For example, if your hospital or health system delegates responsibility for collections to a third-party agency, as many do, the agency's activities should be governed by written policies adopted by the healthcare organization and agreed to by the agency. This will help ensure that collection

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Key Board Takeaways

A healthcare customer's experience throughout the financial cycle can largely affect their overall satisfaction with the hospital or health system. Below are five strategies for boards to guide their healthcare organizations toward better financial experiences and outcomes for patients:

- Build the financial experience around respect for patients.
- Prevent financial toxicity.
- Elevate the role of frontline patient access staff.
- Recognize that the financial experience continues after discharge.
- Convey your commitment to the community.

1 "Best Practices for Patient Financial Communications," HFMA (see www.hfma.org/communications).

2 Eric Topol, *The Patient Will See You Now: The Future of Medicine Is in Your Hands,* Basic Books, 2015.

3 Peter A. Ubel, M.D., Amy P. Abernethy, M.D., Ph.D., and S. Yousuf Zafar, M.D., M.H.S., "Full Disclosure: Out-of-Pocket Costs as Side Effects," *The New England Journal of Medicine,* October 17, 2013 (available at http://bit.ly/1iXK3Yt).

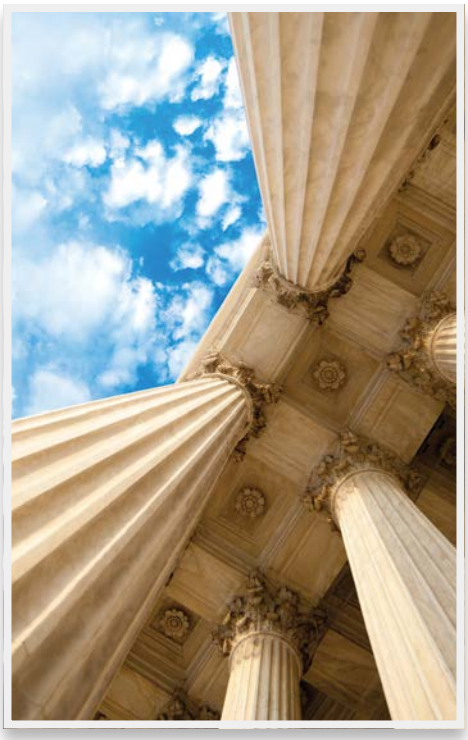
Hospital and Health System Mergers and Acquisitions: Key Legal Issues for the Board

BY ANJANA D. PATEL, EPSTEIN BECKER & GREEN, P.C.

The healthcare industry has been transformed in the last five years since the passage of the Affordable Care Act (ACA) as more and more organizations merge, acquire, or consolidate with others. Under the ACA, the shift in focus from keeping patients out of the hospital and increasing preventative care has led to a decline in hospital revenues, while at the same time the cost of doing business has risen due to increased government regulations and heightened enforcement against providers.

Add to this the ACA's reward/penalty system aimed at incentivizing better quality of care and care coordination amongst providers, and the result is increased pressure on hospitals and health systems to "grab" a larger geographic footprint and scale to better compete in this evolving marketplace. The rise in post-ACA mergers, acquisitions, consolidations, and affiliation transactions ("consolidation transactions") have, in large part, been driven by these challenges as hospitals and health systems seek to more effectively manage larger patient populations, better align physician incentives, assume and manage risk, expand service lines, and invest in information technology and other infrastructure.

While horizontal consolidation transactions continue amongst hospitals and health systems, also on the increase are vertical transactions among hospitals, physicians, and insurance companies as healthcare organizations position themselves to access products and services such as data analytic systems, telemedicine, mobile apps, and other digital technologies to support their population health management and risk assumption initiatives.



Whether your organization is a standalone community hospital or a multihospital health system, consolidation transactions present unique legal and regulatory risks that board members should be cognizant of in connection with the exercise of their fiduciary duties to the organization. This article discusses some of the key legal and regulatory issues for the board's consideration in pursuing a consolidation transaction.

In addition, it is important for board members to understand how these transactions work in order to effectively manage timelines and expectations. Thus, for example, if an organization is contemplating a consolidation transaction for primarily financial needs, the board should have an understanding of how quickly (or not so quickly) these transactions can be consummated and the impact on the institution if the transaction will not be completed within a certain timeframe.

Key Board Takeaways

Hospitals and health systems continue to merge both horizontally and also vertically with physicians and other healthcare providers and health plans. Consolidation transactions present unique legal and regulatory risks that board members should be cognizant of in connection with the exercise of their fiduciary duties to the organization. Some issues for the board to consider when pursuing consolidation transactions include:

- Properly exercising the board's fiduciary duties is important from a regulatory perspective, especially if state law requires the transaction to be approved by the state attorney general. Board actions will be scrutinized to determine if it properly exercised its fiduciary duties to approve a transaction that is fair and reasonable.
- A proactive board will not only conduct due diligence on the target, but also on themselves to ensure that both organizations are a good fit for each other.
- "Reverse" due diligence by the seller on the buyer can help minimize board scrutiny by the state attorney general or other regulators, as well as community interest groups.
- Do not wait until late in the negotiations to discuss management succession planning. Many transactions have died late in the game because the parties did not tackle this sensitive issue early on.

The Board's Fiduciary Duties

From both a corporate law perspective, as well as regulatory compliance perspective, it is important that the board is intimately involved in the consolidation transaction, not only from the beginning, but throughout the entire transaction.

From a corporate law standpoint, board members owe fiduciary duties to the entity they serve. These fiduciary duties are typically characterized as the duty of care, the

duty of loyalty, and in the case of non-profit organizations, the duty of obedience. The duty of care requires a board member to exercise prudent judgment and act in the same manner as a reasonable person would in like circumstances.

A consolidation transaction will also likely require board approval under the hospital's corporate governing documents (i.e., its article of incorporation and/or bylaws). Very often board approvals in connection with consolidation transactions are obtained in multiple phases. Thus, for example, the initial decision to pursue a consolidation transaction may involve the establishment of a steering committee comprised of some board members, as well as hospital management. The steering committee is usually tasked with exploring possible strategic transactions and identifying prospective suitors. The steering committee then reports to the larger board with its recommendations of whether a consolidation transaction should be pursued and with whom.

The exercise of the duty of care may require the board to consider engaging third-party experts to independently assess the organization for its strategic strengths and weaknesses. This type of "pre-consolidation transaction" assessment may help surface any major legal and compliance issues that could be a deterrent to potential buyers. In addition, the hospital may wish to engage a consultant to assist the board with identifying potential partners, the potential synergies, advantages, and disadvantages of each partner, as well as helping the board with evaluating competing offers from multiple buyers or strategic partners.

The duty of loyalty is generally characterized by a board member not engaging in self-dealing, meaning that the board member does not put his or her interests before the interests of the organization. Thus, it is very important that any potential conflicts of interest are vetted out early on in the process. The duty of obedience requires the board to ensure that its decisions are faithful to the mission of the organization. For example, the board of a non-profit hospital considering a consolidation transaction with a for-profit buyer may have to consider what mission-oriented "must-haves" it should negotiate and obtain from this type of buyer.

The board should keep in mind that the proper exercise of its fiduciary duties is also important from a regulatory perspective, especially if state law requires the consolidation transaction to be approved by the state attorney general. To that end, all decisions and actions of the board, from establishing a steering committee and selecting third-party consultants to actually approving potential suitors and the terms of the transaction, should be reflected in reasonable detail in the board minutes to demonstrate the board's deliberative process.

Structuring the Consolidation Transaction

A threshold legal question that will need to be answered is how to structure the transaction. The typical transaction structures are a stock purchase, an asset purchase, a merger, or a consolidation of two organizations. A stock purchase/sale or merger transaction will result in the buyer assuming all of the assets and liabilities of the seller. An asset transaction enables the buyer to cherry-pick the assets and liabilities of the seller that it will assume.

One important consideration from a buyer's perspective that may affect the structure of the transaction is successor liability (i.e., the extent to which the buyer inherits a seller's liabilities). In the healthcare industry, this could be a major area of concern if there are significant financial obligations of the selling hospital to the government through its participation in federal and state healthcare programs. In this scenario, a buyer is likely to be more comfortable with an asset transaction rather than a stock purchase or merger transaction.

Sometimes, however, the parties will have limited flexibility to determine the structure of the transaction. For example, if the buyer is not already participating in federal and state healthcare programs and will need the selling hospital's government participation agreements and provider numbers post-closing, then it will inherit any healthcare program liabilities of the seller if it assumes those participation agreements. In addition, if the selling hospital is a non-profit entity and the buyer is a for-profit entity, most states' laws will not permit a stock/membership interest purchase or merger transaction and the parties will have no choice but to structure the transaction as an asset purchase.

Lastly, other concerns such as debt structure may drive the structure of the transaction. This concern is common in consolidation transactions between two major non-profit health systems with multiple provider facilities, where each system has an existing bond-financed debt structure that may be too complicated to restructure quickly. In this scenario, the transaction structure may involve combining the two systems by creating a super-parent above the existing health systems to preserve and keep intact their respective debt structures.

The proper exercise of the board's fiduciary duties is important from a corporate and regulatory perspective. All decisions and actions of the board, from establishing a steering committee and selecting third-party consultants to actually approving potential suitors and the terms of the transaction, should be reflected in reasonable detail in the board minutes to demonstrate the board's deliberative process.

Due Diligence

Another important aspect of a board member's exercise of his or her fiduciary duties arises in connection with due diligence. As a board member of a buyer, it is critical to ensure that extensive and detailed due diligence is conducted into the seller's operations, financial condition, legal and regulatory compliance, workforce, medical staff, facilities, and community standing. Moreover, a proactive board will not only conduct due diligence on the target, but also on themselves to ensure that both organizations are a good fit for each other and to ensure that both organizations are not bringing major liabilities to the transaction.

Due diligence not only protects the buyer, it can also protect the seller. Very often, the seller will conduct "reverse" due diligence on the buyer. This is especially true if the board's actions will be scrutinized by the state attorney general or other regulators, as well as community interest groups. By engaging in a review of the buyer, including its financial wherewithal, strategic direction, past acquisitions, and its successes and failures, the seller's board will also have a better sense of whether

the buyer is a good fit, both operationally and culturally.

Particular care should be taken when conducting due diligence with respect to sharing sensitive and potentially competitive information. For example, sharing pricing information could raise antitrust concerns that may be alleviated through the use of "clean teams" to facilitate the disclosure being sought by the buyer. Another example is sharing information about potential or actual fraud and abuse violations could be used by would-be whistleblowers. One strategy to deal with these issues may be for the seller to voluntarily self-disclose and attempt to resolve the fraud and abuse violations in order to avoid the buyer walking away from the transaction. These types of compliance issues, which may be discovered in due diligence by the buyer, highlight the reason why the board may wish to engage a third party, prior to entering into a consolidation transaction, to independently review the hospital's financial relationships with physicians and other vendors for fraud and abuse violations, as well as other major legal and regulatory compliance areas, such as billing and coding, HIPAA, privacy and security, lax employment practices, joint employer liability concerns, etc.

The scope and thoroughness of the due diligence conducted will be critical in helping to assess potential liability and risk areas for the buyer and how the transaction is structured and risk allocated between the parties in their definitive agreement.

Negotiating the Definitive Agreement

Concurrently with the course of the due diligence, the parties will be negotiating the definitive agreement. Among the major areas of focus for these negotiations are:

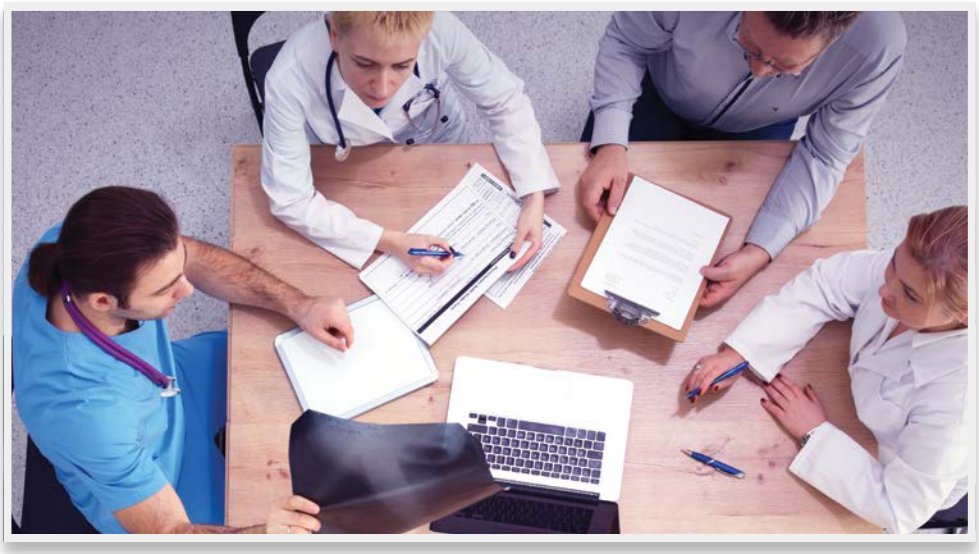
- **The financial terms**, including whether the transaction will be contingent on the buyer obtaining financing and whether the seller will finance any portion of the purchase.
- **The governance rights of the seller (if any) following the closing**. Governance issues may be hotly negotiated if the board of a selling hospital demands representation on the buyer's board for a period of time following the closing, or in a consolidation transaction between two health systems where a new "super-parent" is created to combine the systems.
- **Management structure**. One area that is very sensitive and thus not dealt with early on is the fate of the seller's C-suite executives following the closing. Many transactions have died late in the game because the parties did not tackle this sensitive issue early on.
- **The seller's representations and warranties**. The board should understand that the majority of the definitive agreement will be devoted to the seller's representations and warranties. From a seller's perspective, the fewer statements it makes about its business, the better, as it is less likely that a buyer can call out a breach post-closing. Conversely, from a buyer's perspective, the seller should make broad, comprehensive representations about the business it is selling. A seller will also want to negotiate a finite "end" date by which it is no longer responsible for its representations and warranties—usually between 12 to 24 months—and after which the seller's liability to the buyer is released. A buyer on the other hand will seek to extend this period for as long as possible in order to keep the seller at risk for breaches of its representations and warranties.
- **Indemnification**, which is a risk allocation mechanism between the parties for breaches of representations and warranties and non-compliance with other provisions of the definitive agreement. This provision is often very heavily negotiated. From the buyer's perspective, indemnification can be effectively used to mitigate successor liability, especially for healthcare-related liabilities if the buyer has to assume the seller's government participation agreements for other reasons. Indemnification can be useful, but sometimes it's either not available (for example, the liabilities arise many years after the closing and the seller is long gone) or it's not applicable (for example, in transactions where the buyer will take over an entire hospital or health system and there will be no seller or assets left behind after the closing), in which case, it is even more important that the buyer's due diligence is thorough and identifies potential risk areas.
- **Escrow, holdbacks, and guarantees**. Also common is for the buyer to require that a portion of the purchase price be set aside in escrow or held back for a time period (usually between 12–24 months) following the closing to fund any liabilities that arise after the closing. Alternatively or in addition to an escrow or holdback, the buyer may also insist a corporate guaranty of the seller's parent (if applicable).
- **Restrictive covenants**. Restrictive covenants such as non-competes in favor of the buyer, and "take-back" provisions or rights of first refusal in favor of the seller, are also sometimes heavily negotiated.

Regulatory Approvals

Once the definitive agreement is signed, the focus of the parties will turn towards obtaining the necessary state, federal, and other third-party consents and approvals required for the parties to go to closing. At the state level, these approvals may include approval by the state department of health to transfer licenses and certificates of need, and approval of the state attorney general to transfer the charitable assets of a non-profit hospital. It is imperative that the board understand what notifications and approvals are required and the timeframes that each may take in order to ensure that the timing for obtaining these approvals does not become a major setback.

The transfer of a hospital's acute care and other licenses and certificates of need (if applicable) may involve a simple notification and/or application to the state department of health, or a more lengthier process involving public hearings and input from the community and various stakeholders. In some states, the department of health may also require the buyer to submit "track record" information about itself from any other state where it operates hospitals or other licensed healthcare facilities, as part of the application and approval process.

In a number of states, the transfer by a non-profit hospital of its assets requires approval of the state attorney general under what is known typically as a "conversion statute" or under the attorney general's common law jurisdiction. In some states, the conversion statute only applies if the non-profit hospital is selling to a for-profit buyer; while in other states, the statute applies regardless of whether the buyer is non-profit or for-profit. Further, in some states, if the buyer is a for-profit, the review process may be more heightened than if the buyer is a non-profit, and the selling hospital may be required to obtain an independent valuation, appraisal, or fairness



opinion to comply with the attorney general's requirements.

The attorney general will be tasked with reviewing the transaction from the perspective of whether it is fair and reasonable for the non-profit seller. Specific scrutiny will be focused on the board's actions and decisions during the entire transaction timeline to determine if the board properly exercised its fiduciary duties to approve a transaction that is fair and reasonable for the selling hospital. Hence the need for the board to demonstrate its deliberative process and diligence in selecting the particular buyer.

The attorney general's review will also focus on any restricted gifts that the selling hospital or any affiliated foundation holds. Depending on the nature of the gift and the restriction, the board should be prepared if the attorney general requires that such gifts be submitted to a court in a *cy pres* hearing to determine their ultimate disposition.

There may also be approvals and consents required at the federal level. A threshold concern is whether the transaction triggers the application of the antitrust laws. Transactions in excess of certain dollar thresholds will require a mandatory notification filing under the Hart-Scott-Rodino (HSR) Act. But even if the transaction is below the dollar threshold for an HSR filing, it may trigger antitrust scrutiny if it is between competitors. The board should note that the federal government has been very active in its antitrust enforcement against healthcare providers in recent years.

In addition to antitrust concerns, the parties should assess whether any filings are required to be made to Medicare and Medicaid. Depending on the structure of the transaction, a "change of ownership" (or CHOW) filing, and corresponding approval from Medicare, may be required to transfer ownership of the selling hospital. Alternatively, some transactions merely require a "change of information" (or CHIN) filing, which is a notification to and not an approval from Medicare.

For buyers that are not already participants in Medicare, the easier pathway is to assume the selling hospital's participation agreement because a *de novo* Medicare enrollment application requires a lengthy survey and certification process. Buyers that will be assuming a seller's Medicare participation agreement need to understand how a CHOW approval works because it may have a significant impact on cash flow following the closing. This is because there may be a period of time following the closing, while the CHOW is being processed, during which Medicare will continue to pay the seller for services that the buyer is providing. Once the CHOW is approved, it will be retroactive to the closing and Medicare will start paying the buyer. However, for this interim period, it is important that the buyer negotiate provisions in the definitive agreement obligating the seller to turn over its funds. Conversely, the seller should likewise ensure protections in the definitive agreement for itself relative to any payments received by the buyer after the closing for services provided by the seller pre-closing, including any overpayments or payments from closing cost reports.

Other Approvals, Notifications

Consolidation transactions often involve a myriad of other approvals, notifications, and consents that must (or should) be obtained. Some other key approvals or notifications include:

- Reviewing debt documents, such as bond financing documents to determine if the selling hospital needs to obtain lender or bondholder approval to release any liens on its assets and/or to consummate the transaction
- Distributing any notifications required under the federal Worker Adjustment and Retraining Notification Act of 1988 (WARN) and/or any state equivalent, which may or may not be identical to federal WARN and thus have different or additional obligations
- Notifying all applicable accreditation organizations such as The Joint Commission
- Obtaining any necessary consents under various third-party contracts and leases that a buyer may be assuming
- Filing any requisite applications for transferring miscellaneous licenses, permits, registrations (e.g., radiology, pharmacy, CDS, DEA, CLIA, blood bank, medical waste, boilers, elevators, etc.)
- Approvals from the Catholic Church (if applicable)

Conclusion

The upward tick in consolidation transactions is likely to continue in the near future. As noted above, not only are hospitals and health systems consolidating horizontally, but they are also engaging in vertical transactions with physicians and other providers and health plans, and these types of transactions are likely to substantially increase in the near future. There are many interrelated legal and regulatory aspects to the various components of these transactions. Board members who have an understanding of the juxtaposition of the exercise of their fiduciary duties with the legal and regulatory issues arising in these transactions will be better positioned to help their organizations navigate these transactions.

The Governance Institute thanks Anjana D. Patel, a Member of Epstein Becker & Green, P.C., for contributing this article. She can be reached at adpatel@ebglaw.com. Ms. Patel would like to acknowledge Tristan Potter-Strait, a Law Clerk with the firm, for her assistance with this article.

Standalone Hospitals: Making the Most of Alliances

BY LAURA P. JACOBS, M.P.H., GE HEALTHCARE CAMDEN GROUP

Hospitals large and small are embroiled in conversations about alliances. Larger systems are looking for opportunities to expand, and smaller, standalone hospitals are considering relationships with systems, medical groups, or other hospitals. The reasons vary: access to capital, sharing infrastructure costs, assistance with new payment models, and filling specialty or other medical resource needs are among the most common. Too many times, though, the lofty potential identified in initial discussions between parties ends up either going nowhere or worse, ends in disappointment or unfruitful relationships. Consider the following as your organization thinks about whether an alliance or other type of relationship with another provider makes sense, and if so, how to make the most of the relationship to ensure that your goals are fulfilled successfully.

Know Thyself

As with any new initiative, it is critical that your organization be clear about its vision and current situation. As a smaller hospital or critical access hospital (CAH), resources are especially precious—including management's time and attention. Evaluating either potential or current alliances through a screen of what your organization's needs are is crucial. Having a clear sense of the financial, strategic, clinical, and operational gaps that could be filled through an alliance with another provider is a question that management, and ultimately the board, must answer. For example, if physician recruitment is the primary concern, that will drive the evaluation of potential partners, which could include larger medical groups, a system in a neighboring community, or even a health plan. A focus on evolving to new payment models such as shared savings/accountable care may yield a different set of possible partners.

Don't forget about the strengths your organization could bring to the relationship. This could include community reputation/relationship with the medical community and community services, strong primary care network, funding as a CAH or rural health provider, as well as others that the board identifies. A sound footing of clarity on the organization's strengths and weaknesses, as well as strategic aims will help guide decision making throughout the process.

Clarify Expectations

Once you have articulated what the organization *needs*, it is important to determine expectations from both parties. For example, what degree of control do you/your partner want on certain decisions? What degree of integration is desired/expected of both parties? This could include integration of clinical and/or operational processes, management structures, information sharing (financial, clinical, operational), and even facility use. Determining the financial terms is often a focus of discussion (e.g., capital commitment, management fees, funds flow in the case of gains/losses), and is fundamental, but don't forget about the cultural fit and communication required to make the relationship work. In other words, the board should expect that a complete business plan that includes financial projections as well as operational, strategic, and clinical implications be prepared and accepted by both parties.

Consider the Type of Affiliation

The range of affiliation options can include forging a relationship for clinical service coverage up to a full merger or acquisition. The form that the affiliation takes must fit the goals as well as the mutual expectations and needs of both organizations. Many rural facilities require the backup of full-service hospitals to provide coverage for trauma or other specialty services. There may be additional opportunities to broaden these relationships through participation in bundled payment initiatives or other clinical service line strategies. When considering the next step in an affiliation (e.g., support for population health management or administrative infrastructure support), be sure that the partnership you are forging is supported by your medical staff and reinforces or enhances your organization's brand and reputation. Many organizations today are establishing "clinically integrated" relationships with accountable care organizations (ACOs) or health systems to enable participation in new payment models. When considering the expansion of outpatient or diagnostic services, think about the options of joint venturing with either specialty companies (e.g., for outpatient surgery centers or urgent care centers) or a larger health system to provide capital and/or management expertise. The bottom line is, there are many "flavors" of affiliation options that can be considered that don't have to include a full merger.

What About the Patients?

Many affiliation discussions become consumed with issues such as governance, control, financial obligations, and operational considerations. The most successful alliances in the long-run, though, also pay close attention to the impact on patients. How will clinical information be shared among providers so that patients receive consistent advice and follow-up care? Will there be cultural or geographic barriers to patients receiving care at an affiliated provider? In some regions, weather, long distances, or frequent road closures mean that

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Key Board Takeaways

In this age of consolidation across the healthcare industry, most boards consider one form of affiliation or another with increasing frequency. These affiliations can be extremely beneficial or sidetrack the organization's progress, depending on the strategic, clinical, operational, and cultural fit as well as the level of commitment to a defined set of goals. Key takeaways for consideration include:

- Ensure that your organization has a clear sense of its strategic, clinical, and management priorities and needs, and how an affiliation would help meet them.
- Be clear about both your organization's and your prospective partner's expectations about a relationship—is there alignment?
- Consider a range of possible structures for the affiliation—determine whether you want to "grow into" a broader, more integrated relationship, or jump right in.
- In addition to financial and strategic considerations, ensure that your discussions include the implications to patient care and the patients you serve—how will the relationship enhance patient care and how will it affect the patient experience?
- Once a relationship is forged, review progress on achieving the goals you set out to accomplish—is it achieving what you expected, and if not, what actions need to be taken to rectify that?

The ACA Coverage Expansions…

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who have played an important role in helping people navigate eligibility and plan choices.

Looking Ahead

Over a year after the ACA's major coverage expansions, millions of Americans now have affordable health insurance, allowing them to access the healthcare they need while protecting them against catastrophic medical costs. Looking ahead, several priorities emerge, including reaching the remaining uninsured, translating coverage to care, and ensuring affordable care.

Reaching the Remaining Uninsured

Even with the ACA, continuing gaps in the nation's health insurance system leave 32 million non-elderly people without coverage. About half (49 percent) of the uninsured are eligible for financial assistance through either Medicaid or subsidized Marketplace coverage but are not enrolled.[4] Few uninsured adults say they are uninsured because they do not need coverage, oppose the ACA, or would rather pay the penalty. Rather, most people who remain uninsured have been without coverage for long periods of time or never had coverage. These individuals may be particularly hard to reach and require targeted outreach and enrollment efforts utilizing community-based approaches drawing on providers, grassroots organizations, and assisters.

However, many uninsured people remain outside the reach of the ACA, including low-wage workers who do not qualify for Medicaid or Marketplace subsidies, because they do not meet the income threshold or because they reside in a state that has not expanded Medicaid. In addition, undocumented immigrants are excluded from Medicaid and the Marketplace regardless of their income.

State decisions on the Medicaid expansion have substantially affected access to health coverage for low-income adults. In the 20 states that have not expanded Medicaid, over three million poor adults fall into a "coverage gap." These adults have incomes above Medicaid eligibility limits in their state but below the lower limit for Marketplace premium tax credits. People in the coverage gap are concentrated in Southern states, with the largest numbers in Texas, followed by Florida, Georgia, and North Carolina.[5]

There is no deadline for states to implement the Medicaid expansion, which is fully federally funded through 2016 (phasing down to 90 percent over time), and discussions continue in a number of states. Beyond substantial reductions in their uninsured rates, states that have implemented the Medicaid expansion also report savings in behavioral health, the criminal justice system, and uncompensated care as well as increased revenue as a result. In addition, hospitals and health systems in expansion states show sharp increases in Medicaid stays and sharp declines for the uninsured during 2014.[6,7] Safety net hospitals, which traditionally care for the uninsured, are likely to feel financial pressure, particularly in non-expansion states, as federal payments to disproportionate share hospitals are reduced over time.

Translating Coverage to Care

Adults who have gained coverage through the ACA are experiencing greater access to healthcare and protection from burdensome medical costs than those who remain uninsured. However, newly insured adults face challenges in using the medical system compared to adults who previously had coverage, which may reflect transitions to new care arrangements, difficulty finding a provider, and problems navigating the health system and health insurance networks. Newly insured adults may not fully understand the details of their plan, how their coverage works, and how to make the best decisions to protect themselves from burdensome medical expenses. Given the limited income of newly insured adults, it's not surprising that they tend to be very sensitive to cost in choosing their plan, placing a priority on lower premiums over benefits and provider networks that can lead to challenges when trying to access services through their plan.

Ensuring Affordable Coverage

Although people gaining coverage are less likely to report problems with medical bills than their uninsured counterparts, 44 percent of those who pay a monthly premium report difficulties and 20 percent report higher-than-expected costs under their plan.[8] Affordability remains a concern as even modest healthcare costs can be a major burden for low- and middle-income families and rising out-of-pocket costs can impede efficient care delivery. These issues may be ameliorated by efforts to increase the "health literacy" of newly insured consumers, but addressing affordability may also require additional policy solutions targeted to low- and moderate-income people who must balance health costs against other "pocketbook" issues, including paying for rent, food, utilities, and other basic necessities.

The ACA has provided coverage to millions of people in the United States in its first two years and has the potential to reach many more, ensuring that fewer individuals and families will face the health and financial consequences of not having insurance. With the third open enrollment period upon us, helping people understand and make the best choices in coverage is a priority. At the same time, addressing affordability challenges, eliminating gaps in coverage, and reaching the remaining uninsured continue to warrant the attention of state and federal policymakers.

The Governance Institute thanks Barbara Lyons, Senior Vice President, Kaiser Family Foundation, and Director, Kaiser Commission on Medicaid and the Uninsured, for contributing this article. *She can be reached at barbaral@kff.org.*

4 Rachel Garfield et al., "New Estimates of Eligibility for ACA Coverage among the Uninsured," Kaiser Family Foundation, October 2015.

5 Rachel Garfield and Anthony Damico, "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid—An Update," Kaiser Commission on Medicaid and the Uninsured, October 2015.

6 Peter Cunningham, Rachel Garfield, and Robin Rudowitz, "How Are Hospitals Faring under the Affordable Care Act? Early Experiences from Ascension Health," Kaiser Commission on Medicaid and the Uninsured, April 2015.

7 Robin Rudowitz and Rachel Garfield, "New Analysis Shows States with Medicaid Expansion Experienced Declines in Uninsured Hospital Discharges," Kaiser Commission on Medicaid and the Uninsured, September 2015.

8 Rachel Garfield and Katherine Young, "How Does Gaining Coverage Affect People's Lives? Access, Utilization, and Financial Security among Newly Insured Adults," Kaiser Commission on Medicaid and the Uninsured, June 2015.

The Role of Financial Communication...

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practices are aligned with a healthcare organization's values.[4]

Convey your commitment to the community. Good news rarely commands extensive media attention. Hospitals and health systems that are committed to delivering positive financial experiences need to find other ways to let the community know about it (e.g., through marketing, outreach events, newsletters, and online information).[5]

Going forward, success for healthcare providers will increasingly hinge on treating patients as full partners in their healthcare. In the clinical arena, this shift is well under way. It's time to bring our approach to the patient's financial experience into alignment with contemporary values and expectations as well.

The Governance Institute thanks Joseph J. Fifer, FHFMA, CPA, President and CEO of the Healthcare Financial Management Association, for contributing this article. He can be reached at jfifer@hfma.org. More information about the best practices and recommendations described in this article is available at www.hfma.org/dollars.

4 For other recommendations, see *Best Practices for Resolution of Medical Accounts: A Report from the Medical Debt Collection Task Force,* HFMA, January 2014 (available at http://bit.ly/1SxWbeW).

5 HFMA has a Patient Financial Communications Adopter Recognition Program for hospitals that have adopted its best practices. For more information, see http://bit.ly/1lrRGYP.

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more creative solutions, such as telemedicine, may be necessary to facilitate access to needed clinical services. The traditional referral relationships between physicians should be considered in establishing the affiliate partner. Changing referral patterns is like learning to write with your other hand—the failure rate is high unless there is strong motivation to stick with it.

Think About the Future

Sometimes affiliations are pursued to solve an immediate problem (e.g., physician shortage, lack of coverage, financial shortfall). Think about where this affiliation might lead over time. Will there be opportunities to expand the relationship, and if so, is that desired or not by your board and management team? What is the likely long-term commitment of your potential partner? Is it dependent on a single person (i.e., CEO or clinical leader), or is there broad-based organizational commitment? The more informal or less integrated the relationship is, the easier it is to get going, but also the harder it is to rely on long term. Depending on your goals, that may be fine—just be sure that you are aligned with your partner on both the short-term and long-term aspirations.

Be Cautious of Having Too Many "Dates"

As a smaller facility, there may be many reasons to establish relationships with larger organizations, or even peer group facilities. In some cases, this could lead to a potpourri of affiliations (one for physician resources, one for purchasing, one for population heath, etc.). While not a fatal flaw, it can limit the ability to optimize the effectiveness of your affiliate relationship(s). It can also be quite distracting or confusing to your management and clinical teams.

Entering into relationships with other organizations, particularly in these challenging times, must be carefully planned, astutely negotiated, and deliberately monitored to ensure that the goals you identify at the outset are achieved successfully. Don't be afraid to streamline your relationships and "pick" a partner if it will mean realizing your organization's vision and meeting the community's healthcare needs.

The Governance Institute thanks Laura Jacobs, President, GE Healthcare Camden Group, for contributing this article. She can be reached at ljacobs@thecamdengroup.com.

Consumer Commission...

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- Provide a platform for marketing/planning to share their work and gain valuable board feedback.
- Ensure "consumerism" is a source of input to the organization instead of an ambiguous external force.
- Commit to a frequency for review and correction of activities based on consumer views.

Much like the requirements of a consumer commission member, the activities described above are congruent with the skill set and duties of a board member. Improving what we do for those we serve is at the heart of consumerism, and it's firmly in line with the focus of the board. As myriad factors push healthcare in a bold new direction, the need for reinvention is necessary. Consumers are calling for more information, more education, and even more transparency throughout their healthcare experiences. The board, a longtime fixture of healthcare, is primed to guide and support such reinvention. Not revolution, but rather a shift in purpose and support for new voices in an effort to improve healthcare for all. Consumers and the board may seem like strange bedfellows but as healthcare evolves they may make quite the match.

The Governance Institute thanks Ryan Donohue, Corporate Director of Program Development, National Research Corporation, and Governance Institute Advisor, for contributing this article. He can be reached at rdonohue@nationalresearch.com.

Consumer Commission: Defining the Board's Role in Addressing and Advancing Consumerism

BY RYAN DONOHUE, NATIONAL RESEARCH CORPORATION

As with any group of people drawn together under a common objective, personalities form the fiber of a board. At the most basic level, boards are comprised of people from different walks of life, touting experience from various industries, with views that are individually unique. In healthcare boards, these personalities do have one shared trait: the bravery to shepherd an organization through massive change in an inherently complex industry.

Beyond bravery, board members from outside of healthcare are instilled with an intriguing duality: they maintain one foot in their native industry and the other in healthcare. But because healthcare is so complex and ever-changing, something interesting happens to the theoretical (and ideal) duality of the board member. In most cases, it vanishes. Board members may arrive with fresh, "off-campus" ideas for improving healthcare, but they become indoctrinated by healthcare's labyrinth-like thinking and overmatched by the entrenched barriers to change present in every corner of healthcare. Their outside experience often becomes a casualty of orientation.

There are good intentions to this abandonment—for one to learn and understand a new field they must actively guard against assumption. In healthcare, board members have much to learn. They're likely to be there because they have a keen interest in healthcare, perhaps a desire to learn more and make a difference in such a vital industry. Board members may feel another desire: a longing to be accepted by the more tenured, established members of the board. In this conundrum, board members may give up their initial ideals for change to be accepted.

Healthcare, however, is not an industry that can afford to defer to current thinking. After decades of ignoring consumer—and even patient—perspectives in favor of nurturing physician and payer relations, healthcare is pricing itself into a mess. Costs are out of control, physicians and nurses are burnt out, and patients are left holding the bill and wanting for more. Fueled in part by health reform, and in large part by the need for more affordable care, consumers have had enough of the current state of healthcare. The industry is now teetering on the brink of a consumer-led transformation.

Industry stakeholders are in desperate need of understanding their audience—an audience they've paid little attention to until now. As necessitated by population health, they must discover what makes consumers tick. To confront these challenges, the healthcare industry and the hospitals and health systems it comprises are in dire need of outside perspective. This quality is made abundantly available through the dynamic of a board. How to harness this unique perspective became an area of intense focus.

Focusing the Board on Consumerism

A few years ago, after lecturing on consumerism at a Governance Institute Leadership Conference, I was asked—or rather tasked—by a forward-thinking board member of a fairly advanced health system to put together the criteria for members of a "consumer commission," a group of organizational stakeholders who track the consumer perspective and report back to senior leadership in order to include it during the formation of strategy. This internal force is sorely lacking in most hospitals and health systems as most struggle to regularly incorporate the patient perspective into their strategy—let alone the broader consumer view. Following my lecture, this board member dutifully requested I take this thinking to the next step and truly define its structure and, perhaps more importantly, its members. As I turned to the whiteboard, I was struck by a very simple idea: the consumer commission already exists within all organizations. It's known as the board of directors.

The board has an ability to inform the outside, consumer point of view perhaps better than any other structure within the organization. Consider the qualities necessary for my "consumer commission" concept:

- Influence within and outside of the healthcare industry
- A working knowledge of the local community, including its nuances and pitfalls
- A working knowledge of the hospital or health system and its governance, finances, and operations
- An ability to meet frequently and consistently to cover topics of importance
- The desire to set performance goals for the organization—and the time to track them

The above qualities are word-for-word what I defined as criteria for members of a consumer commission. Yet no nationwide executive search will be necessary. Those who fit this criteria are already installed within the organization. In fact, they've already formed a group and meet with a determined frequency. If you have a board, you have a consumer commission just waiting for activation.

Should you choose to move forward with this idea, there are a few things to consider. Like any group, there must be goals installed to track activity. The board has many duties—CEO compensation, regulatory fulfillment, etc. Yet all of those activities serve the ultimate purpose of improving the care provided to consumers. To that end, a few essential directives for your new (old) consumer commission:

- Keep the pulse of the community—know when issues are bubbling up before they hit it big.
- Be brand guardians through measuring and managing perceptions and satisfaction (including internal and external brand strengths—and weaknesses).
- Develop a strategic plan for how to measure consumer sentiment toward organizational activity.

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Key Board Takeaways

Healthcare organizations need to understand what makes consumers tick. Forming a "consumer commission" that tracks the consumer perspective and reports back to senior leadership can help in these efforts. The board has the outside perspective and know-how to make up this group. A few essential directives for a consumer commission include:

- Keep the pulse of the community.
- Be brand guardians through measuring and managing perceptions/satisfaction.
- Develop a strategic plan for how to measure consumer sentiment toward organizational activity.
- Commit to a frequency for review and correction of activities based on consumer views.