



## Getting Aligned: Strategic Affiliations for Community Providers

Karen Kole, Principal, ECG Management Consultants  
Leah D'Aurora Richardson, Partner, Foley & Lardner LLP

 AMERICAN HEALTH LAW ASSOCIATION

1

A “community provider” generally refers to an organization or individual that provides services to a community and may include entities like hospitals and clinics.

2

# Agenda



1	Overview: Drivers, Benefits, and Challenges to Strategic Affiliations
2	Strategic Affiliations: Principal Business and Regulatory Considerations
3	Common Affiliation Models: Model Structures and Principal Considerations
4	Funds Flow and Valuations: Approach to Fair Market Value (FMV) and Financial Considerations
5	Case Studies

# Overview

## Drivers, Benefits, and Challenges to Strategic Affiliations





## What type of affiliations have you worked on between a community provider and another hospital?

i The Slido app must be installed on every computer you're presenting from

slido

5

## Key Challenges Faced by Community Hospitals



The challenges below are causing community hospitals to find alternative solutions in order to remain independent.

### Low Patient Volumes

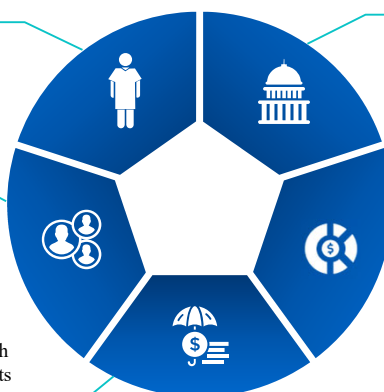
Decreasing populations and shifts to seek care in urban centers have decreased patient volumes, leading to challenges in offsetting overhead costs required for specialty care.

### Workforce Recruitment and Retention

With fewer rural clinical training programs and universities, hospitals may struggle to recruit and retain trainees and full-time staff.

### Payment Program Dependence

Heavy reliance on state and federal funding with high volumes of Medicare and Medicaid patients creates financial uncertainty with policy changes.



### Federal Hospital Support

The majority of rural hospitals receive direct federal funding support through special payments to help offset costs and support uncompensated care; recent potential policy changes may limit this support.

### Medicaid-Funded Patient Base

In rural areas, 19% of discharges have Medicaid as the payer; with potential changes to Medicaid eligibility, there may be higher rates of uncompensated care going forward.

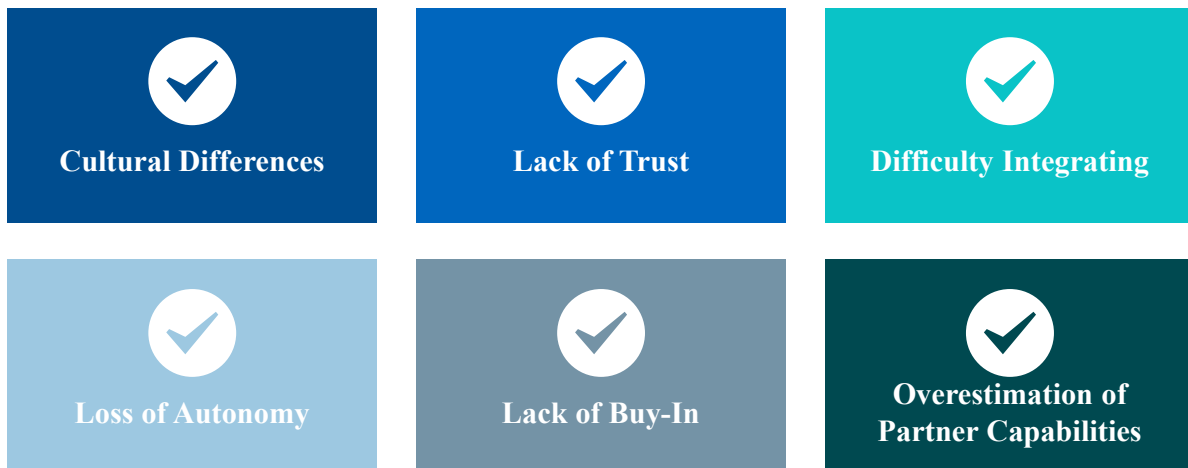
Sources: KFF, "10 Things to Know About Rural Hospitals," 2025 and KFF, "Rural Hospitals Face Renewed Financial Challenges, Especially in States That Have Not Expanded Medicaid," 2023.

6

## Community Provider Strategic Affiliations: Benefits

- Branding and patient draw
- Economies of scale
- Leadership and management training and support opportunities
- Improved ability to manage defined populations and coordination of patient-centric care
- Alignment for quality and efficiency
- Shared resources, risks, and rewards
- Opportunity to improve clinical and financial data systems
- Access to specialists
- Access to clinical trials and other research opportunities

## Community Provider Strategic Affiliations: Challenges



# Strategic Affiliations

Principal Business and Regulatory Considerations



9

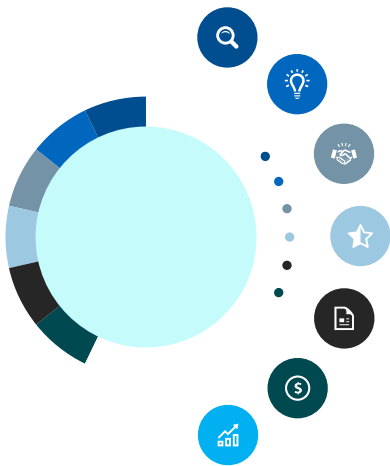
## Principal Business Considerations



- Scope of contractual arrangement or venture
- Branding and name use rights
- Governance structure and decision-making
- Capital contributions and distributions and financial relationships
- Bond restrictions/ Obligated group issues
- Dilution
- Federal tax considerations (UBTI)
- Noncompetition and other restrictive covenants
- Term/termination
- Buy-in/buy-out
- Dispute resolution
- Succession planning

10

## Principal Regulatory Compliance Considerations



- **Fraud and Abuse Laws (Federal and State)**
- **Antitrust Considerations and Unfair Competition**
- **Tax Exemption Issues**
- **Licensure and Certificate of Need/Determination of Need**
- **Reimbursement Considerations, Including the Anti-Markup Rule**
- **Provider-Based Rules and Co-location Requirements**
- **Privacy and Security (HIPAA)**

## Key Healthcare Regulatory Laws



### Federal Anti-Kickback Statute (AKS)

- This criminal statute prohibits any person from knowingly and willfully offering or paying any remuneration, directly or indirectly, in cash or in kind, to induce a person to make referrals for items or services that are covered by federal healthcare programs.
- Statutory exceptions and regulatory safe harbors, promulgated by the Office of Inspector General of the Department of Health and Human Services (OIG), specify the arrangements that will not be subject to prosecution under the AKS.

### OIG Guidance

- OIG has issued various forms of guidance concerning joint venture arrangements, including the 1989 Special Fraud Alert: Joint Venture Arrangements (reprinted in 1994) and the 2003 Special Advisory Bulletin on Contractual Joint Ventures.
- Advisory Opinions on healthcare joint ventures and comanagement arrangements are instructive.

## Key Healthcare Regulatory Laws *(continued)*

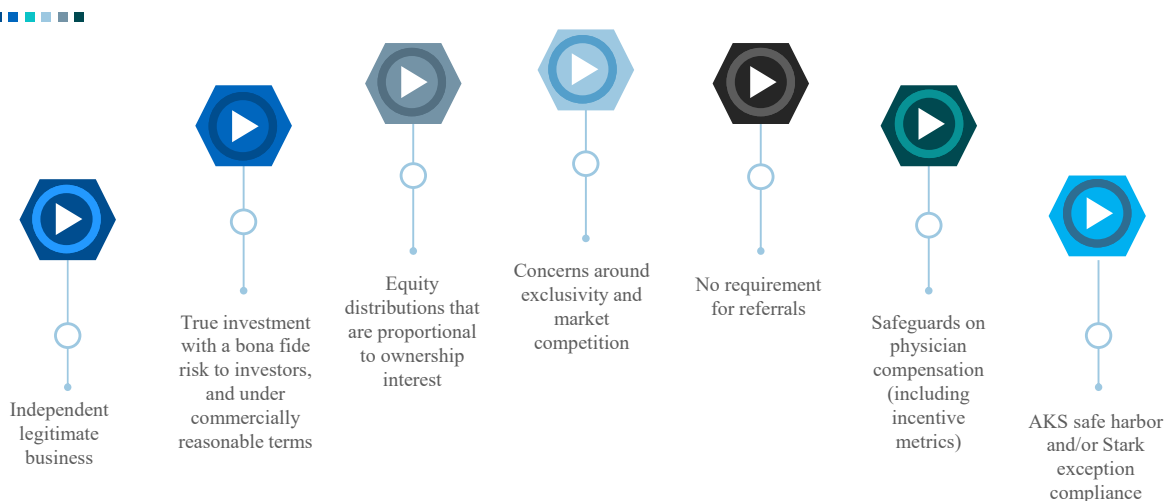
### Federal Physician Self-Referral Law (Stark law)

- This civil statute prohibits a physician from referring Medicare patients for designated health services to an entity with which the physician (or an immediate family member) has a financial relationship, unless an exception applies.
- It applies to contractual or ownership interests.
- Stark will be implicated if a physician is in a position to refer designated health services to an organization in which the physician has a financial interest and needs to be considered if there will be physician ownership in the joint venture entity.
- Arrangements between the joint venture entity and physicians must satisfy a Stark exception.

### State Considerations

- Many states have versions of Stark or AKS that may have similar, and often identical, elements of applicable exceptions.
- Prohibitions on the corporate practice of medicine should be considered.

## Key Healthcare Regulatory Compliance Concepts



## Common AKS Safe Harbor Features



### Personal and Management Services, Equipment Lease, and Space Lease Safe Harbors

- In writing, signed by the parties, Covers all services to be furnished, At least a one-year term
- Commercially reasonable services
- Compensation methodology
  - Set in advance
  - Consistent with FMV
  - Not determined in a manner that takes into account the volume or value of referrals

### Small Entity Investment and ASC Safe Harbors

- Specific requirements for how investment interests are offered and structured
- Return on investment (equity distributions) must be proportional to capital contributions
- Specific requirements regarding services provided by the invested entity, ensuring compensation is FMV and does not incentivize referrals

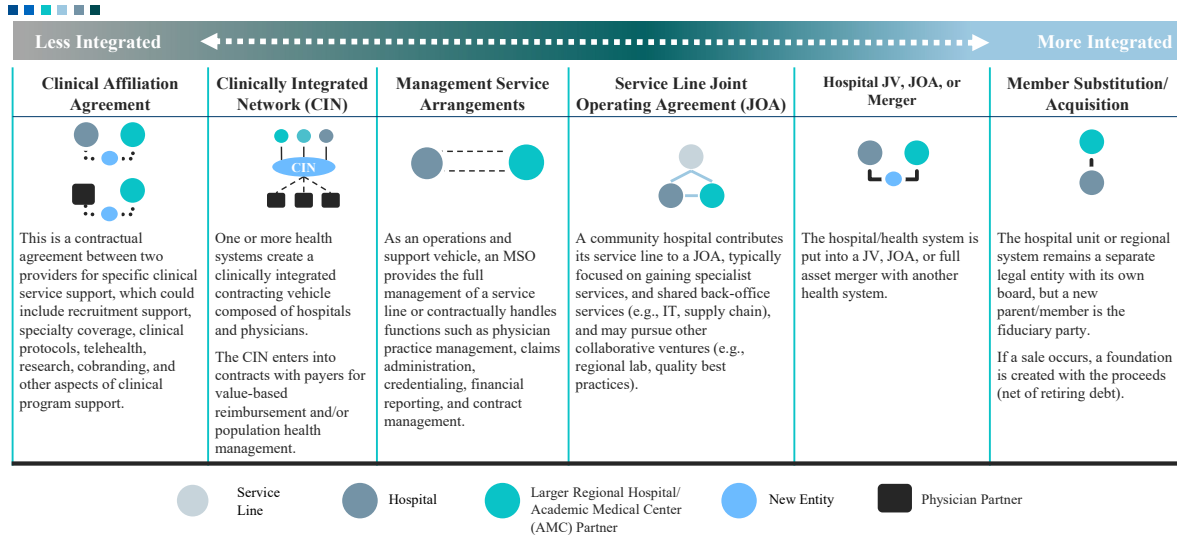
# Common Affiliation Models

## Model Structures and Principal Considerations





## Range of Community and Rural Provider Affiliation Models

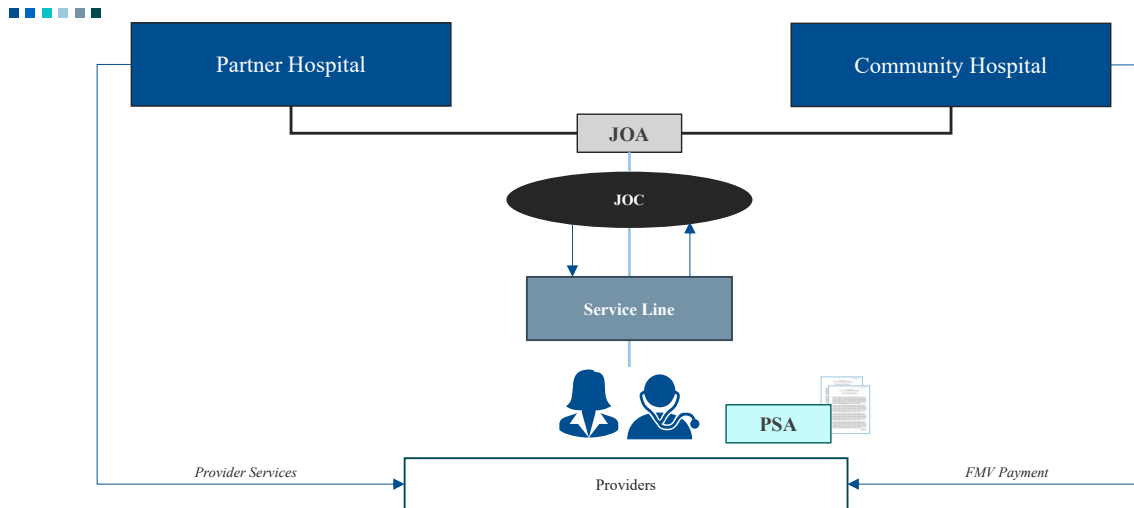


## Service Line JOA

### Principal Considerations

□ □ □ □ □

## Service Line JOA Straw Model



19 | Getting Aligned | June 30, 2025

AMERICAN HEALTH LAW ASSOCIATION

19



**What service lines have you utilized a JOA for?**

**Do not edit**  
How to change the  
design

① The Slido app must be installed on every computer you're presenting from

**slido**

20

## Service Line JOA Overview



A contractual agreement creating a loose relationship to collaborate on specific initiatives, such as programs and services, branding, joint community service planning, and other efforts (also called “virtual merger”)

### Advantages

- Allows parties to gain experience working together before considering a more comprehensive business combination
- Leads to improved patient care, as the community hospital gains the experience of the partner hospital
- Enhances patient access, as the service line is kept in the community
- Enables coordinated care with specialists from the partner hospital

### Disadvantages

- Failure to fulfill the broad partnership objectives of a more integrated business combination
- Lack of engagement from the partner organization due to looser alignment
- Hesitancy to share data
- Accounting complexity
- Arrangement fraud and abuse compliance

## When should a service line JOA be utilized?

- The service line is struggling economically or operationally.
- Parties’ objectives for entering affiliation are limited.
- There is not enough volume to provide quality care.



## Key Items to Consider When Structuring a JOA



- 1 Each hospital maintains its own operations.
- 2 The JOA board consists of representatives from both hospitals and has authority over the service line.
- 3 Each party should be involved in performance goal setting and set meaningful targets.
- 4 Parties agree on the scope of service and how those are defined.
- 5 Determine how to incorporate clinics that are creating significant losses.
- 6 Organizations continue to bill for services under their own licenses, payer contracts, and provider numbers.
- 7 Determining which party owns the assets and how they are included in the JOA is key, especially for specialties with negative margin.

## Key Fraud and Abuse Compliance Safeguards



- Avoid suspect features outlined in OIG's joint venture guidance.
- Implement regulatory guardrails outlined in various government publications, including:
  - No incentives for physicians or other providers to refer to the venture.
  - No tracking of referrals from participants or other referral sources.
  - No physician compensation tied to value or volume of referrals to the venture.
  - Financial disclosures to patients.
- Ensure financial arrangements between participants and the venture (whether contractual or involving a new joint operating company) meet AKS safe harbor/applicable Stark law exceptions.
- If the service line JOA implements a goal to reduce costs, review CMP Law—Gainsharing Guidance and implement regulatory guardrails.
- Obtain independent fair market valuation to support all financial arrangements.*

## Other Key Compliance Considerations



### Antitrust Considerations

- Similar analysis for JOCs as for mergers under antitrust laws and guidance
- Antitrust counsel should be engaged to review proposed arrangement



### Tax Exemption Issues

- Adverse effect on tax exemption of JOA participants
- Activities resulting in private use of tax-exempt bond proceeds
- Activities deemed unrelated trade or business/UBTI generation
  - IRS has issued many PLRs opining on tax exemption related to JOAs



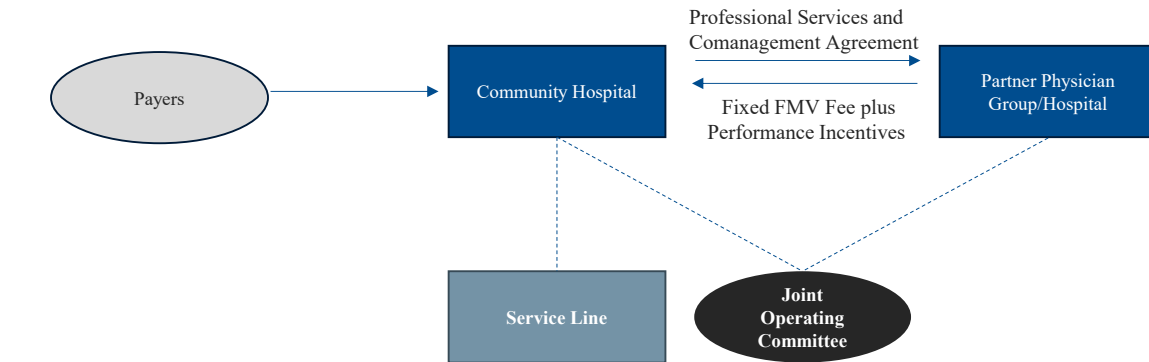
- HSR and state equivalent notification requirements must be assessed

## Management/Comanagement Arrangements

### Principal Considerations



## Service Line Comanagement Arrangement: Direct Contract Model

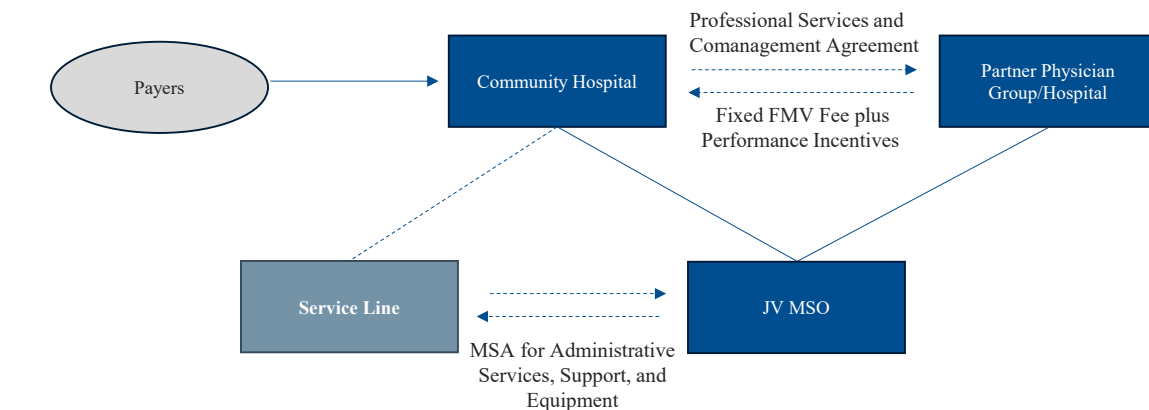


27 | Getting Aligned | June 30, 2025

AMERICAN HEALTH LAW ASSOCIATION

27

## Service Line Comanagement Arrangement: Joint Venture MSO Model



28 | Getting Aligned | June 30, 2025

AMERICAN HEALTH LAW ASSOCIATION

28

## Comanagement/Management Arrangements Overview



Contractual arrangements provide shared responsibility for the service line by appropriately rewarding the partner hospital/physicians for efforts in managing and improving the quality and efficiency of a hospital service line.

- Generally meant to ensure service line quality improvement, patient access, and sustainability
- Governance through JOC consisting of representatives from community hospital and partner, but community hospital that owns the service line must have ultimate control



Typically, funds flow through two levels of payment:

- A fixed FMV annual base fee for the time the medical groups/physicians dedicate to the service line management, development, implementation, and oversight processes
- Predetermined incentive payments associated with the achievement of specified, mutually agreed-upon, and objectively measurable quality improvement and efficiency goals

## Comanagement/Management Arrangements Overview (continued)



### Advantages

- Are quick to execute/implement as mechanism for using physician competencies to manage variety of service lines
- Align hospital and physicians around service line quality and efficiency
- Optimize service lines while maximizing physician engagement
- Optimize clinical and administrative processes
- Improve patient experience and outcomes
- Maintain hospital reimbursement for service lines
- If a JV MSO formed: low capital investment, minimal investment risk, financial returns

### Disadvantages


- Commitment of 2%–6% of service line revenue
- Need active participation/real-time effort by MDs
- Gaps in communication/lack of stakeholder engagement
- Lack of adequate long-term benefits for the community provider (financial motivations primary driver versus efficiency, cost, patient experience)
- Onerous target setting and continual resetting of quality targets relative to baseline levels
- Need to reevaluate/replace fully optimized or achieved metrics for multiple consecutive years
- Some irreducible regulatory risk

## Comanagement/Management Services Examples



✓ Development of service line	✓ Patient scheduling
✓ Medical director services	✓ Staff scheduling and supervision
✓ Budget process	✓ Human resource management
✓ Strategic/business planning process	✓ Case management activities (e.g., discharge planning, arranging follow-up services, callback processes)
✓ Community relations and education	✓ Materials management
✓ Patient, physician, and staff satisfaction surveys	✓ Medical staff-related activities and committee participation
✓ Development of clinical protocols and performance standards	✓ Credentialing assistance
✓ Ongoing assessment of clinical environment and workflow processes	✓ Coordination with and reporting to hospital
✓ Physician staffing	

## Key Fraud and Abuse Compliance Safeguards



<ul style="list-style-type: none"> <li>Volume-/revenue-based performance measures implicate the AKS. <ul style="list-style-type: none"> <li>No rewards to increase in utilization, revenue, or profits of service line</li> <li>No rewards for change in case mix</li> <li>No rewards for change in acuity</li> </ul> </li> </ul>	
<ul style="list-style-type: none"> <li>Gainsharing metrics should include regulatory safeguards. <ul style="list-style-type: none"> <li>Community hospital can incentivize verifiable cost savings from standardizing supplies or reducing administrative expenses as long as quality is not adversely affected and volume/case mix changes are not rewarded.</li> </ul> </li> </ul>	
<ul style="list-style-type: none"> <li><i>Obtain independent fair market valuation to support all financial arrangements.</i></li> </ul>	



# Funds Flow and Valuations

## Approach to FMV and Financial Considerations

□ □ □ □ □

Standards of Value: When performing a valuation of a business, services, or fixed assets, the standard of value must be determined.



### FMV

- The price, expressed in terms of cash equivalents, at which property would change hands between a hypothetical willing-and-able buyer and a hypothetical willing-and-able seller, acting at arm's length in an open and unrestricted market, when neither is under compulsion to buy or sell and when both have reasonable knowledge of the relevant facts
- Cannot consider downstream referrals
- Cannot consider synergies among entities

### Fair Value

- The price that would be received for an asset or paid to transfer a liability in a transaction between marketplace participants on the measurement date
- FASB definition
- For financial reporting purposes
- Certain litigation or shareholder dispute valuations require the standard of value to be fair value

### Strategic (investment) Value

- The value to a particular investor based on individual investment requirements and obligations
- Can consider downstream referrals
- Can consider synergies among entities

## Three Approaches to Value



### Market

- Value is based on market transactions of comparable companies or public company multiples.
- Selected transactions should mirror industry and economic conditions.
- Selected market multiples are applied to subject company metrics, such as EBITDA.



### Cost

- This approach seeks to identify replacement cost.
- It is most commonly applied to the valuation of tangible assets or asset-intensive businesses.



### Income

- This approach considers the financial performance of the organization, entity, or arrangement being valued.
- It relies on the analysis of future cash flows associated with the business.

## Example P&L for Service Line JOA



Illustrative P&L	
<b>Revenue</b>	
Professional Fees/Technical Revenue	
<b>Total Revenue</b>	
<b>Expenses</b>	
PSA Payment	
Staff Salary	
Benefits (allocation)	
Drugs and Supplies	
Other Operating Expenses	
Management Services Fee	
Overhead/Indirect Costs	
Depreciation	
<b>Total Expenses</b>	
<b>Margin/(Loss)</b>	
<b>Research Initiatives</b>	
<b>Programmatic Development</b>	

- The value of each hospital's contribution to the JOA determines "ownership."
- The JOC will establish the financial terms of the agreement.
- If there is profit margin, some funds could be reinvested in the program.
  - Two example areas for reinvestment will be *research initiatives* and *programmatic development*.
- Future capital investments will be the responsibility of the community hospital, but depreciation will be treated as an included expense.
- The income and loss from each hospital's service line are combined and allocated based on the hospitals' respective ownership percentages.

## JOA Valuation: Existing Service Line (one sided)



Ensure both sides are contributing an equal amount of something to the affiliation (e.g., assets, knowledge).

### Community Hospital

- The hospital contributes its services to the JOA.
- The service line value comes from its income stream.
- Tangible assets are often leased to the JOA.
- Goodwill is captured through the cash flow.

### Partner Organization

- It pays cash if the service line was profitable before the affiliation.
- It often provides cobranding and management expertise in which separate arrangements will be structured.



### Common Valuation Flaws

- It does not reflect the actual transaction structure.
- It does not include necessary indirect expenses and overhead.

## JOA Valuation: De Novo



Ensure both sides are contributing an equal amount of something to the affiliation (e.g., assets, knowledge).

### Community Hospital

- Purchases assets and receives lease payment from the JOA
- If a portion of services not new, should be compensated for that
- Indirect expense payment from the JOA

### Partner Organization

- Providing consulting services to help start up the service line that should be compensated for
- Often providing cobranding and management expertise in which separate arrangements will be structured



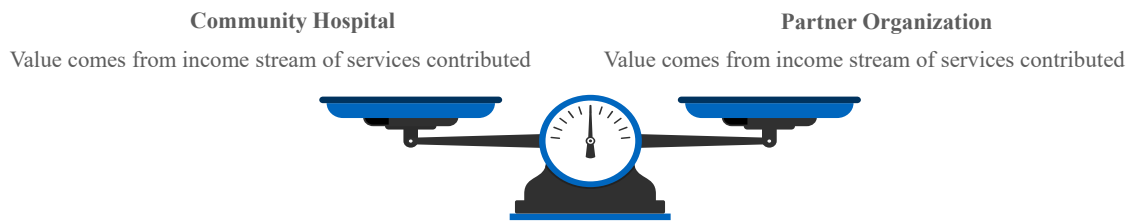
### Common Valuation Flaws

- Does not reflect the actual transaction structure
- Not including necessary indirect expenses and overhead

## JOA Valuation: Existing Service Line (two sided)

Both sides are contributing services to the JOA.

- Ensure both sides are contributing an equal amount of something to the affiliation (e.g., assets, knowledge).
- If one party's services are larger, the entity with the smaller service line will need to contribute cash, or else the JOA funds flow should be adjusted so it is not 50/50 and representative of each service line's value.



### Common Valuation Flaws

- Does not reflect the actual transaction structure
- Not including necessary indirect expenses and overhead

## Management and Comanagement Valuation

### Management Services

- If one party will manage the services going forward, the management fee should be consistent with the market.
- Management services vary widely per arrangement and are not always comparable with market data.
- The manager should try to estimate the time that each individual at the company will spend operating the service line to better support the fee.
- Instead of the larger health system/AMC providing typical management services (finance, HR, marketing, etc.), the services might focus on quality and protocols and could include the following:
  - Care experience
  - Physician recruitment
  - Accreditation, certificates, and licenses
  - Protocols, policies, and procedures
  - Quality

# Cobranding and PSA Valuations



## Cobranding






- Typically, part of an MSA arrangement.
- If the partner hospital's brand will be utilized, they are often compensated for it.
- It is important to clearly establish the restrictions with cobranding, if any, and how the name will be utilized.

## PSA

- This is a multipronged approach.
  - Review FTE, WRVUs, and collections of providers.
- Determine whether it is a coverage-based versus volume specialty.
- Understand all the payment arrangements for the provider.
- If APPs are involved, consider whether the overall payment is still reasonable.

# Five Common Valuation Errors



				
<b>Not Considering All Arrangements in the Transaction</b>	<b>Issuing a Final Valuation Opinion Before the Transaction Terms Are Known</b>	<b>Failing to Identify All Services Included</b>	<b>Utilizing Data That Does Not Accurately Reflect the Arrangement</b>	<b>Giving Credit for Synergies when the Standard of Value Is FMV</b>
<ul style="list-style-type: none"> <li>• Management services</li> <li>• Equipment leases</li> <li>• Cobranding</li> </ul>	<p>If the JOA has a minority partner, it is important to know the supermajority and reserve requirements.</p>	<p>It could be determined that certain clinics should be included. If those clinics incur losses, the valuation will be affected.</p>	<ul style="list-style-type: none"> <li>• Indirect expenses</li> <li>• Rent</li> <li>• Future capital expenditure needs</li> <li>• Working capital</li> </ul>	<p>Cash flow should be based on how the entity can perform without the buyer.</p>

# Case Study



## Case Study: MSA/PSA: Confidential Community Medical Center (CMC) and AMC

### Background

- The CMC is a not-for-profit, acute care hospital in the Southeast with approximately 270 beds. The hospital is city owned and has approximately 190 physicians.
- The AMC is a not-for-profit AMC in the Southeast with 7 hospitals and over 1,700 beds. It is a comprehensive research and teaching hospital.

### Opportunity

- The CMC needed to maintain its oncology services; however, multiple physicians (radiation oncologists and medical oncologists) have left the area or retired, and CMC is aware of two additional physicians that are going to retire soon.
- The AMC was going to provide the physicians going forward through a PSA arrangement and also provide management services through an MSA. The MSA will include policies and procedures, protocols, clinical pathways and workflows, and patient communication and education.

### MSA



The CMC will pay the AMC a fixed fee and incentive payment for management services, including strategic planning, developing policies and procedures, and assisting with business development.

### Enhanced Access



The AMC will assist with staffing physicians, dosimetrists, nurse administrators, and the physicians to allow continued access to oncology services at CMC.

### PSA



The CMC's medical oncologists and radiation oncologists are more stable given they are staffed through the AMC.

### Enhanced Patient Care



The arrangement helps standardize oncology care at the CMC, and staff learn best practices from an NCI-designated program.

# Case Study: Service Line JOA: Bozeman Health and St. Peter's Health

## Background

- Bozeman Health is a not-for-profit acute care hospital serving southwest Montana with approximately 133 beds. The hospital has 250 medical providers across 40 clinical specialties.
- St. Peter's Health is a not-for-profit health system that includes a 99-bed acute care hospital, physician clinics, a cancer treatment center, a 24-bed behavioral health unit, urgent care clinics, home health and hospice care, a dialysis center, and ambulance services.

## Opportunity

- Both health systems wanted to develop a program for neonatal care and maternal-fetal medicine (MFM) services that would bring a higher level of care to families in southwest Montana.
- Together, the systems could establish a Center of Excellence for neonatal care and MFM services and bring specialized care closer to home for Montana patients.
- Families with high-risk pregnancies who live in Helena can utilize technology during appointments with their OB/GYN for telehealth consults with the MFM physician in Bozeman.

### Funds Flow



The parties had to determine how to account for indirect expenses and clinic losses.

### Enhanced Access



The JOA created an opportunity to contract with subspecialists, thus allowing patients to remain closer to home while receiving care.

### Service Offering



The parties had to determine what services should be included and whether some services should be contributed a year or two after the relationship was formed.

### Enhanced Patient Care



The arrangement helps standardize neonatal care and allows for a higher-level NICU.

## Questions?

**Karen Kole**  
Principal, ECG

[kkole@ecgmc.com](mailto:kkole@ecgmc.com)

303 West Madison,  
Suite 2100  
Chicago, Illinois 60606

312-637-2500

**Leah D'Aurora  
Richardson**

Partner, Foley & Lardner

[leah.richardson@foley.com](mailto:leah.richardson@foley.com)

5000 Centregreen Way,  
Suite 500  
Cary, North Carolina 27513

984-375-3051



© 2025 is published by the American Health Law Association. All rights reserved. No part of this publication may be reproduced in any form except by prior written permission from the publisher. Printed in the United States of America.

Any views or advice offered in this publication are those of its authors and should not be construed as the position of the American Health Law Association.

“This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is provided with the understanding that the publisher is not engaged in rendering legal or other professional services. If legal advice or other expert assistance is required, the services of a competent professional person should be sought” —from a declaration of the American Bar Association.

