2025

L. EDWARD BRYANT, JR.
NATIONAL HEALTH LAW
TRANSACTIONAL COMPETITION

OFFICIAL PROBLEM

Introduction

Bryant Health System ("BHS") has retained your law firm to provide legal and strategic counsel on a potential partnership, affiliation, or other arrangement with Oncology Alliance Group ("OAG"), a consortium of independent for-profit oncology practices operating throughout the state of Loyola. The Strategic Planning Committee of BHS, comprised of the CEO, CFO, and select Board Members, has initiated discussions regarding this opportunity as part of BHS's long-term goal to enhance its oncology services and expand its regional footprint.

BHS is a leading Catholic, not-for-profit, integrated healthcare system operating in multiple states, including Loyola, and delivering a range of services across urban, suburban, and rural settings. Known for its comprehensive offerings, BHS seeks to deepen its oncology services by forming a strategic affiliation with OAG to coordinate oncology care across a wider geographic area, integrating clinical services, and improving access to innovative treatments. A key priority for BHS is to reinvigorate its rural markets, including its critical access hospital, Pearson Medical Center, ensuring that underserved populations have improved access to comprehensive cancer treatment.

Background

Bryant Health System

Founded in 1965, BHS has grown into a regional healthcare powerhouse, dedicated to patient-centered care, innovation, and accessibility. BHS operates:

- Ten acute care hospitals, three of which are designated as Level II trauma centers.
- Fifteen outpatient clinics, located in both urban and rural areas and offering primary care, urgent care, and specialty services, including oncology.
- Five specialty care facilities, including a dedicated cardiac center, a behavioral health unit, and an advanced imaging center.

BHS employs over 12,000 healthcare professionals, with a yearly operating budget of $1.5 billion, but has faced recent challenges such as:

- A recent 10% decline in revenue due to increased competition, particularly from for-profit health systems entering the market.
- Elevated operational costs stemming from staffing shortages, particularly in nursing and specialized fields. BHS has recently initiated an aggressive recruitment campaign to attract healthcare professionals to address staffing shortages. While this campaign has received media coverage and positive responses from the community, it has further strained the budget.
- Ongoing investments in technology, including a new electronic health record ("EHR") system, which has temporarily strained resources.

BHS recently launched a new telehealth platform aimed at providing virtual care to patients in its rural markets. While this initiative has garnered positive attention and patient engagement, it has led to increased operational costs due to the need for additional IT support and cybersecurity measures. BHS is also involved in a high-profile community health initiative that focuses on improving maternal health outcomes in Loyola. While this initiative has received state funding

and community support, it has also diverted resources and attention from BHS's oncology expansion plans, creating tension among leadership regarding prioritization of projects.

BHS has made oncology a priority due to increasing cancer incidence and gaps in coordinated cancer care across its service area. The organization has invested heavily in clinical trials, advanced treatment modalities, and multidisciplinary cancer care teams. Despite solid financial footing, BHS faces pressure to maintain operational efficiency in a changing healthcare reimbursement landscape, particularly due to recent state-level policy changes in Loyola that affect Medicaid and Medicare reimbursement.

Oncology Alliance Group

OAG consists of five independent oncology practices offering medical oncology, radiation therapy, and palliative care services, and operates two proton beam therapy centers. Although These practices are loosely connected through a management board that provides limited coordination on business, management, and strategic decisions, such as compensation, business development, staffing, and strategic planning. OAG's member practices refer a significant portion of their patients to OAG-owned ancillary services, including radiation therapy and imaging. Each practice retains its own autonomy. Each practice retains its own autonomy.

OAG serves around 8,000 patients annually, with a large Medicare and Medicaid population. OAG has seen revenue drop from $20 million to $15 million over three years, primarily due to increased competition. The organization also faces regulatory challenges, including compliance with updated patient safety protocols. OAG remains known for clinical excellence, despite financial struggles. It is a trusted provider in its community, having participated in clinical trials and developed robust palliative care programs. Notwithstanding, OAG has faced difficulty recruiting and retaining oncologists due to competitive pressures and a shrinking talent pool in Loyola. Recently, OAG has also been in discussions with a private equity firm interested in investing in its practices to stabilize operations and enhance profitability.

OAG has several existing financial arrangements with some pharmaceutical companies and device manufacturers and leases several of its clinics from third-party owners, who are unaware of the proposed affiliation. These leases contain provisions requiring landlord consent before a change in management or control.

OAG has recently undergone a CMS survey, which uncovered deficiencies in its radiation therapy services related to equipment sterilization and record-keeping. OAG has submitted a corrective action plan to CMS, which is pending CMS review. CMS also raised concerns about inadequate cybersecurity protections in OAG's existing electronic health record system and about patient data security, particularly as the practices expand their use of telemedicine. OAG has faced allegations of non-compliance with state-level Medicaid reimbursement regulations, particularly involving documentation of services provided to low-income patients. Additionally, two of OAG's member practices are currently engaged in a dispute with a commercial payor regarding denied claims, leading to additional financial strain.

The independent physicians within OAG have expressed concerns about how an affiliation with BHS will impact their clinical autonomy and decision-making. Some members worry that BHS's corporate governance structure may impose restrictions on how they run their practices, such as

standardizing treatment protocols or limiting their ability to participate in clinical research independent of BHS.

Loyola Law

The state of Loyola currently has the following laws:

- **Loyola Charity Care Act (LCCA):** Requires nonprofit healthcare providers to provide a minimum of 5% of their annual operating budget in charity care to low-income patients. The law mandates that all charity care must be documented and reported annually to the state's Department of Health.
- **Proton Beam Therapy Regulation (PBTR):** Establishes stringent operational and clinical protocols for the use of proton beam therapy, including patient eligibility criteria and quality assurance measures. Facilities operating such services must submit biannual reports detailing treatment outcomes and compliance with safety standards.
- **Independent Practice Integration Act (IPIA):** Prohibits the acquisition or merger of for-profit practices by nonprofit health systems unless the transaction results in demonstrable improvements in access to care and is approved by the state's Attorney General. The law also mandates a public comment period prior to approval.
- **Patient Referral Transparency Law (PRTL):** Requires all healthcare providers to disclose referral relationships and financial incentives associated with ancillary services, including imaging and therapy. Providers must obtain informed consent from patients before referring them to affiliated services.
- **Rural Healthcare Access Improvement Act (RHAIA):** Mandates that healthcare systems developing partnerships in rural areas demonstrate how they will enhance healthcare delivery and accessibility. The law provides incentives for projects that include telehealth services and mobile clinics.
- **Confidentiality of Health Records Act (CHRA):** Enhances protections for patient health information, requiring all healthcare entities to implement robust cybersecurity measures and conduct annual audits to ensure compliance with data protection standards.
- **Anti-Kickback Compliance Framework (AKCF):** Establishes a state-level framework that mirrors federal anti-kickback laws, with additional provisions for the healthcare industry to avoid any financial incentives that could compromise patient care. Violations could result in hefty fines and loss of licensure.
- **Corporate Practice of Medicine:** Prohibits the corporate practice of medicine by restricting business corporations from engaging in the practice of medicine or employing physicians to render medical services.

<u>Assistance Required</u>

BHS is seeking your counsel to develop and guide them through the various options available for a potential strategic affiliation, partnership, or other arrangement with OAG. BHS has asked you to, at minimum, provide feedback and guidance on the following factors in the course of providing your proposed options:

1. Assess the strategic, cultural, and operational factors that BHS should consider before proceeding with each proposed arrangement.

2. Analyze the regulatory risks posed by each option presented, including the risk exposure and solutions on how to address or mitigate risks at both the federal and state levels. Include risks that may arise both pre- and post-transaction.
3. Identify potential liabilities that BHS could inherit through each option. Propose strategies for addressing these risks during the process of effectuating each option.
4. Outline areas for supplemental due diligence and identify whether they are high or low priority, as well as your objectives with your diligence requests.
5. In addition to providing the pros and cons of each proposed option, provide an ultimate recommendation on how BHS should proceed out of the options presented and your rationale.
6. Identify any key missing facts that could impact your ultimate recommendation and how your analysis would change.

BRYANT
HEALTH
SYSTEM

TRANSACTIONAL MEMORANDUM

2025

PREPARED BY:
TEAM 11

TEAM 11 LAW, PC
LOYOLA, LOYOLA

Table of Contents

I. INTRODUCTION

Bryant Health System (BHS), a Catholic non-profit healthcare system, is evaluating a potential affiliation with Oncology Alliance Group (OAG), a network of five independent oncology practices loosely connected through a management board. This memorandum examines the strategic, operational, and cultural factors shaping the potential affiliation, presents various affiliation options, analyzes associated regulatory and liability risks, and outlines the supplemental due diligence required before advancing with any affiliation strategy.

We recommend that BHS considers one of four potential affiliation models: (1) mergers and acquisitions (M&A), (2) joint ventures (JVs), (3) contractual affiliations, and (4) no action. These affiliation options vary in financial investment, regulatory complexity, liability exposure, and time commitment, providing BHS with a range of choices tailored to its strategic priorities.

II. STRATEGIC, CULTURAL, AND OPERATIONAL CONSIDERATIONS

Understanding each group's strategic goals, cultural values, and operational structure is integral to identifying synergies and mitigating potential areas of conflict in any affiliation. Through an affiliation, BHS aims to enhance oncology care across a broader geographic area, integrate clinical services, and improve access to innovative treatments. A primary focus is to revitalize rural markets, particularly Pearson Medical Center (PMC), its critical access hospital (CAH). BHS has experienced a revenue decline in recent years, partially due to successful, though costly, technology initiatives like telehealth and implementing an electronic health record (EHR) system. Other operational stressors include staffing shortages due to competition for skilled healthcare professionals in Loyola, strained resources from a maternal health initiative and investment into innovative treatments, and adjusting to state-level Medicare and Medicaid changes, all of which has led to tension amongst BHS's leadership.

Fortunately, OAG offers solutions to some of BHS's strategic and operational needs. Contracting with OAG's physicians and other non-physician staff can resolve some of BHS's staffing concerns and increase access to care. Furthermore, OAG is renowned for its clinical excellence and innovative treatments, such as its proton beam therapy practice. If BHS collaborates with OAG physicians and is exposed to their expertise and resources, BHS can gain the tools necessary to expand its clinical capabilities and enhance innovative treatments. Additionally, because OAG serves a large Medicare and Medicaid population, an affiliation with shared patient care would allow BHS to reach an increased rural population over a broader geographic area.

However, OAG has strategic and operational considerations of its own. OAG has similarly experienced a drop in revenue and stressors regarding EHRs. Notably, OAG has various compliance-related issues with both federal and state regulations that pose a serious financial threat, as discussed further below. OAG's operational deficiencies suggest a lack of strong central management overseeing day-to-day operations. Moreover, OAG has been in discussions with private equity to stabilize operations and boost profits. BHS's tax-exempt status practically prevents affiliation with OAG if it receives private equity investment.

Regarding BHS's non-profit status, unique challenges arise if BHS desires to maintain its tax exemption. BHS's federal tax-exempt status is dependent on BHS's non-profit status as determined by Loyola, adherence to IRS Code 501(c)(3) requirements, and participation in public aid programs such as Medicare and Medicaid. Therefore, BHS must continue to abide by Loyola's state-specific non-profit requirements like the Loyola Charity Care Act (LCCA), which requires nonprofits to provide at least 5% of their annual operating budget in charity care to low-income patients, document all charity care, and provide annual reports to Loyola's Department of Health. Because any affiliation has the potential to increase revenue if successful, BHS must pay special

attention to its charity requirements under LCCA. Whether a specific affiliation results in revocation of BHS's tax-exempt status is not a bright-line determination. Recommendations are offered throughout this memorandum to best avoid adverse tax consequences. But, as explained by one Catholic hospital leader, non-profit designation is merely a tax status and is not demonstrative of a hospital's purpose.[1]

Perhaps the most vital consideration for an affiliation is culture as physician-health system collaborations often depend on aligning financial objectives, core values, and patient care priorities.[2] Recognizing financial motivation differences is crucial when a non-profit and for-profit collaborate. Given OAG's position in a lucrative industry, BHS may face resistance with financial decisions if OAG physicians prioritize higher salaries or return on investment over reinvesting revenue into BHS's charitable mission. Financial motivations could also influence patient selection, as OAG may opt to not treat uninsured indigent patients without legal requirements to do so. This possibility is particularly important given BHS's desire to expand access to care in rural markets, where many patients lack meaningful insurance coverage.

BHS should also consider any tension that may arise due to differences in values surrounding the Catholic faith. To maintain BHS's Catholic designation, it must operate in accordance with the Ethical and Religious Directives for Catholic Health Care Services (ERDs). Part Six of the ERDs acknowledges that collaboration with non-Catholic entities can benefit the community by furthering Catholic teachings and providing greater access to healthcare that may

[1] Michael J. O'Laughlin, *When a Catholic Hospital Becomes For-Profit*, AM. THE JESUIT REV. (May 16, 2024), https://www.americamagazine.org/faith/2024/05/16/catholic-hospitals-profit-mission-247913.
[2] *Six Physician Alignment Strategies Health Systems Can Consider*, DELOITTE, https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-six-physician-alignment-strategies.pdf.

not otherwise exist.[3] However, the ERDs explicitly warn against collaboration with entities that engage in "immoral acts," such as abortion, physician-assisted suicide, and sterilization.[4] While direct participation in immoral acts is strictly prohibited, Catholic entities have discretion to permit some instances of indirect participation without immoral intentions for the greater good.[5]

While violating an ERD may not have dire state or federal penalties, losing status as a Catholic health system may affect public perception, patient base, financials, employee retention, and much more. Further, if tied to BHS's non-profit status, loss of Catholic status may have adverse tax consequences, including the potential to be stripped of its tax-exempt status. Although it is unknown whether OAG is engaged in "immoral acts," OAG has expressed a clear desire to maintain autonomy with regards to its medical and clinical decisions and research initiatives. Ultimately, if the tension imposing ERDs on OAG's physicians escalates high enough, it could affect the success of the affiliation or dissuade an affiliation altogether.

Finally, BHS should be mindful of its reputation as a non-profit, Catholic organization seeking to expand care in rural areas. BHS's potential affiliation with OAG may be perceived as solely for financial gain. But, considering BHS's desire to expand treatment options for rural patients and OAG's need for more stringent documentation of its low-income services to remain eligible for federal reimbursement programs, efficient branding and advertisement can be used to highlight each organization's desire to collaborate in order to improve the community.

III. REGULATORY CONSIDERATIONS AND CONCERNS

A potential affiliation between BHS and OAG involves navigating a complex landscape of state and federal regulations. While some regulatory concerns are unique to the chosen affiliation

[3] *Ethical and Religious Directives for Catholic Health Care Services*, U.S. CONF. OF CATH. BISHOPS 1, 23, https://www.usccb.org/resources/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06_0.pdf.
[4] *Id.* at 24.
[5] *Id.*

structure, this section provides BHS with a broad overview of applicable regulations and identifies risks associated with OAG's current non-compliance. Unless otherwise noted, the regulatory risks and compliance concerns outlined in this section apply to all affiliation options—except for the "no action" option. The key distinction is whether BHS assumes direct liability for OAG's compliance issues or faces secondary repercussions resulting from them. Here, we discuss the impacts of (1) federal regulations, (2) state regulations, and (3) OAG's existing regulatory concerns on an affiliation with OAG.

A. Federal Regulations

At the federal level, key regulatory risks primarily involve three major healthcare laws: (1) the Anti-Kickback Statute (AKS), (2) the Stark Law, and (3) the False Claims Act (FCA). While Stark violations are subject only to civil penalties, AKS violations impose criminal liability, and the FCA carries both civil and criminal consequences, depending on intent to defraud.[6] Penalties for violating these are exceptionally severe and have often led to the closure of healthcare facilities, underscoring the importance of compliance.[7]

The AKS makes it a crime to knowingly or willfully accept or pay remuneration to induce patient referrals.[8] Given AKS's broad scope, which effectively covers all healthcare transactions, it is essential to structure the affiliation to align with safe harbors as BHS's goals require shared patient care between OAG and BHS. Currently, OAG contracts with pharmaceutical companies and device manufacturers. These contracts often pose AKS risks, making a thorough investigation of these agreements a critical component of due diligence.

---

[6] *Fraud & Abuse Laws*, U.S. DEP'T. OF HEALTH & HUM. SERVS. OIG, https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/.

[7] For instance, violations of the FCA can result in penalties ranging from $12,000 to $25,000 per claim, along with treble damages.

[8] 42 U.S.C. § 1320a-7b(b).

Similarly, Stark prohibits physicians from referring patients for designated health services (DHS) to entities with which they have a financial relationship unless an exception applies.[9] Because OAG refers patients to its own ancillary services, it is critical to assess whether these arrangements qualify for an applicable exception. Further, if the ancillary services become part of the affiliation, the new arrangement should be structured to fit within an exception as well.

The FCA imposes liability on entities that knowingly submit, or cause to be submitted, false or fraudulent claims to the federal government.[10] The FCA also encompasses situations where physicians submit non-fraudulent claims, receive overpayment, and fail to remit the overpayment.[11] Although current OAG practices do not seem to amount to fraud, deficiencies in recordkeeping may lead to overlooking instances of overpayment and inaccurate billing. Further, submitting Medicare and Medicaid claims based on violations of AKS and Stark are also FCA violations.[12]

In addition to the three major healthcare laws, BHS should also carefully examine regulations regarding CMS Certification Numbers (CCNs), the Health Insurance Portability and Accountability Act (HIPAA), and antitrust laws. Every healthcare facility that is certified as a Medicare and Medicaid provider has their own CCN. Depending on the type of affiliation BHS decides to pursue with OAG, the CCN and other licensure information may need to be changed or updated. HIPAA requires healthcare providers to protect the security and privacy of patient information.[13] Dedicating sufficient resources toward ensuring HIPAA compliance will be vital if

[9] 42 C.F.R § 411.351 (defining "[d]esignated health services" to include clinical laboratory services, physical therapy, occupational therapy, radiology services, durable medical equipment, outpatient prescription drugs, inpatient and outpatient hospital services, and more); 42 U.S.C. § 1395nn.
[10] 31 U.S.C. §§ 3729-3733; 18 U.S.C. § 287. A person "knowingly" submits a false claim not only when they "have actual knowledge of the information," but also when they "act in deliberate ignorance" or "reckless disregard" of the truth or falsity of the information.
[11] *Id.*
[12] U.S. DEP'T. OF HEALTH & HUM. SERVS. OIG, *supra* note 6.
[13] 45 C.F.R. §§ 160-164.

the affiliation involves shared patient care. Several antitrust laws, including those prohibiting monopolization and anticompetitive mergers, may be implicated depending on the competitive landscape in Loyola and the chosen affiliation structure. If the transaction is valued over the current Hart-Scott-Rodino Antitrust Improvements Act (HSR) threshold, filings and additional wait periods may encumber M&A or JVs.[14] If antitrust concerns arise, BHS may need to provide pro-competitive justification, and structure the affiliation to mitigate antitrust scrutiny. At a minimum, contractual relationships cannot amount to price-fixing or restraints on trade.

B. State Regulations

Loyola has several state healthcare regulations that BHS should carefully consider when exploring an affiliation with OAG. Loyola's Corporate Practice of Medicine (CPOM) prohibits business corporations from practicing medicine or directly employing physicians. The Patient Referral Transparency Law (PRTL) most closely resembles a state version of the Stark law, but it specifically addresses ancillary and affiliated services by requiring disclosure and informed consent from patients before referring them to affiliated services. Because OAG refers patients to its ancillary services, if affiliated, BHS must update its protocols to include informed consent procedures and ensure that OAG aligns its practices accordingly.

The Anti-Kickback Compliance Framework (AKCF) provides additional provisions for avoiding financial incentives that could compromise patient care. Due to the increased risk of hefty fines or loss of licensure, it is crucial to determine whether there are safe harbors to offer BHS protection. Further, the Rural Healthcare Access Improvement Act (RHAIA) mandates that healthcare partnerships in rural areas demonstrate how they will enhance healthcare delivery and

[14] Effective February 21, 2025, the HSR filing requirements may apply if the transaction is valued at $126.4 million, unless an exemption applies. *See New HSR Thresholds and Filing Fees for 2025*, FED. TRADE COMM'N (Feb. 6, 2025), https://www.ftc.gov/enforcement/competition-matters/2025/02/new-hsr-thresholds-filing-fees-2025.

access. It also provides incentives for telehealth, which could help alleviate the current financial downturn and tension amongst BHS leadership resulting from BHS's recent investment in telehealth. Depending on how broadly partnership is defined, the RHAIA may apply to all affiliations presented.

C. OAG's Existing Regulatory Concerns

In addition to maintaining compliance with federal and state regulations, BHS must carefully consider OAG's current compliance issues and analyze potential liability exposure. At worst, BHS could assume liability; at best, BHS may still face indirect financial consequences through the affiliation.

OAG recently underwent a CMS survey that identified deficiencies in its radiation therapy services with equipment sterilization and record-keeping. If these deficiencies are tied to OAG's proton beam therapy, Loyola's Proton Beam Therapy Regulation (PBTR), which requires stringent operational and clinical protocols for proton beam therapy, could be implicated. In its survey, CMS also raised concerns over OAG's inadequate cybersecurity protections. Inadequacies may trigger Loyola's Confidentiality of Health Records Act (CHRA), which enhances protections for patient health information and requires robust cybersecurity measures and annual audits. Given CMS's report, OAG likely has violated the CHRA and potentially HIPAA, which could result in class action lawsuits or even criminal penalties. Although OAG submitted a corrective action plan, if CMS rejects the plan, OAG may face serious consequences, including civil penalties and exclusion from Medicare and Medicaid reimbursement. Given OAG's tech-related compliance issues, any affiliation will require a comprehensive IT infrastructure executed under centralized management.

OAG also faces other state and federal regulatory challenges that could affect its eligibility to participate in and receive federal healthcare funding. OAG's compliance issues regarding

updated patient safety protocols potentially violates CMS quality and safety standards.[15] Similarly, OAG faces allegations of non-compliance with documentation of services provided to low-income patients. Non-compliance again risks OAG losing funding and may even expose BHS under the LCCA if the non-compliance persists in certain affiliation structures. Further, if any of these violations are severe enough to constitute a lack of or worthless services, or if payment is explicitly contingent on strict compliance, billing for services tied to these deficiencies could expose OAG to FCA liability and other legal actions.

IV. OVERVIEW OF THE PROS AND CONS OF EACH AFFILIATION

Given the strategic, cultural, operational, and regulatory considerations presented above, we have identified four affiliation options, each with their own advantages and challenges. M&A transactions offer the most control, allowing BHS to fully integrate OAG's operations and ensure future regulatory compliance. However, M&A come with high financial costs, significant liability assumption, and antitrust risks, potentially resulting in the affiliation being blocked altogether. Further, if OAG does not wish to work for BHS, as their desire for autonomy suggests, BHS's broader objectives requiring clinical integration and collaborating for treatment innovation may remain unfulfilled.

A JV provides a more collaborative approach, with shared governance and investment, which could help BHS achieve its broader objectives through fostering closer ties with OAG. Further, if structured as an Accountable Care Organization (ACO), the JV may help alleviate the financial concerns of expanding into rural markets. However, JVs are notoriously risky due to tax and regulatory hurdles, and they require OAG to take on a large financial capital investment, which

[15] *Patient Safety Standards*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Sept. 10, 2024), https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualityinitiativesgeninfo/aca-mqi/patient-safety/mqi-patient-safety.

may be difficult given OAG's current financials. Additionally, while JVs offer a higher degree of integration than contractual arrangements, they require significant oversight and coordination.

Contractual affiliations offer a more autonomous and flexible approach than a M&A or JV, allowing BHS to provide operational and administrative support to OAG and gain OAG's physician services without assuming the same level of financial or regulatory risk. These agreements could help mitigate staffing shortages and OAG's compliance issues while keeping BHS at arm's length. Although a Co-Management Arrangement (CMA) would allow OAG's expert input to the cancer service line, it does not offer the same degree of clinical integration or expansion of services BHS might desire. Further, BHS would have limited control and leverage over OAG's long-term decisions, which could leave the door open for private equity investment.

Finally, no affiliation presents the safest option for BHS, avoiding any financial, regulatory, or compliance risks associated with OAG's operations. However, this would mean BHS would need to pursue alternative ways to achieve its oncology goals, potentially facing increased competition in an already stressed market. Additionally, if BHS takes no action, OAG may turn to private equity, making future collaboration difficult, if not impossible.

V. AFFILIATION STRUCTURES AND ANALYSIS

A. Mergers and Acquisitions

M&A transactions have played a significant role in healthcare consolidation across the United States. However, before pursuing an M&A transaction, BHS must consider two key factors. First, if BHS falls under CPOM restrictions, an M&A transaction will not allow BHS to directly employ OAG physicians. To secure physician services, BHS would need to negotiate additional contracts, such as Professional Services Agreements (PSAs). Acquiring OAG without physician retention risks patient attrition and may hinder BHS's broader objectives, including clinical integration and access to OAG's innovative oncological approaches. Second, the financial burden

and subsequent integration efforts of an M&A transaction are substantial. Allocating a significant portion of an already strained budget may limit BHS's ability to expand care into rural areas.

OAG could acquire BHS through either a stock purchase, an asset purchase, or a merger—the main distinctions primarily involving tax implications, cost, and liability assumption. A stock purchase would require BHS to negotiate individually with each of OAG's shareholders, and if successful, result in BHS's full ownership of OAG, including all known and unknown liabilities. Because acquiring OAG's existing compliance issues could be financially devastating to BHS, alternatively, BHS could selectively assume assets and liabilities in an asset purchase. But, these negotiations are costly and time-consuming as they must be addressed on an individual basis. A merger combines some favorable aspects of both stock and asset purchases, streamlining integration while allowing for liability protection with respect to unknown liabilities and trapping known liabilities within a limited liability entity. Although BHS would still need to allocate significant upfront capital to facilitate the transaction, a M&A would allow BHS to gain greater control over OAG's oncology services and remain aligned with its charitable Catholic mission.

i. M&A Regulatory Risks

Loyola's Independent Practice Integration Act (IPIA) requires that all healthcare consolidations demonstrate a clear increase in access to care before securing approval from the Attorney General. Failure to meet this standard could delay or even prevent approval of the transaction. Additionally, if PSAs are necessary to secure OAG's physician services, they will be subject to the same regulatory considerations discussed below.

Tax and antitrust risks also pose significant challenges. If the transaction is not fair market value, the IRS may determine that BHS provided prohibited private benefit to OAG, jeopardizing BHS's tax-exempt status. Antitrust concerns, however, present the biggest uncertainty. Antitrust enforcement can be unpredictable, and in some cases, regulators have blocked M&A transactions

outright. An M&A must be evaluated under current Merger Guidelines from the Federal Trade Commission and Department of Justice.[16]

ii. M&A Liability Assumption and Mitigation

M&A transactions involve the highest liability assumption of the options presented. As noted, stock purchases carry the greatest liability risk, while an asset purchase minimizes exposure—though often at a higher cost. Further, asset purchases (and some mergers) necessitate navigating the change in ownership process (CHOW). Typically, the target's (OAG's) CMS Certification Number (CCN) and provider agreements are assigned to the buyer (BHS).[17] However, if OAG's liability issues are tied to the provider agreements, BHS's Medicare and Medicaid payments could be reduced or recouped. BHS could reject OAG's CCN and provider agreements, but then BHS would be required to negotiate their own new agreements.

Beyond utilizing a merger to structure OAG within a limited liability entity to reduce BHS's exposure, the primary protections for BHS include effective negotiation, such as with indemnification and escrow. However, these measures do not fully eliminate risk. Post-M&A challenges may arise if BHS's primary recourse is against OAG physicians, who may lack the financial resources to cover major compliance violations. This is further complicated if physicians remain with BHS, as pursuing claims may strain professional relationships and disrupt operations.

B. Joint Ventures

Joint Ventures offer an alternative to M&A transactions, providing flexibility that allows both parties to explore operational synergies and evaluate the success of an affiliation before committing to a more permanent integration. Widely utilized in the healthcare industry, JVs enable

[16] *Merger Guidelines*, U.S. DEP'T OF JUST. & FED. TRADE COMM'N (2023).
[17] *See* 42 C.F.R. § 489.18.

organizations to collaborate as a unified economic entity for a specific business purpose, sharing both risks and rewards while maintaining separate corporate structures.[18]

To align with the strategic objectives of BHS and OAG, we propose a JV in which BHS and OAG jointly manage BHS's cancer service line, which would become integrated with OAG's existing oncology practice. This arrangement allows OAG physicians to retain autonomy while advancing BHS's goal of expanding access to cancer care by leveraging the combined resources and expertise of both entities. Additionally, the JV could help address OAG's administrative and operational inefficiencies by incorporating managerial oversight by BHS.

JVs can be structured as purely contractual arrangements—such as through a joint operating agreement—or established as a separate legal entity. A contractual JV would be similar to the co-management arrangement discussed below, but with the key difference that here, both OAG and BHS would hold a financial stake in and bear responsibility for the cancer service line. The choice between a contractual or "incorporated" JV typically depends on factors such as underlying risk of the JV, preference for default entity rules, whether the co-venturers intend to hold joint assets, and the lifetime of the venture. While the decision to "incorporate" the JV may not significantly alter its overall function, (1) regardless of "incorporation," the JV is likely to be treated as a partnership for legal and tax purposes, and (2) if BHS and OAG intend to form an accountable care organization, a separate legal entity is required.

i. Tax-Exempt Status Considerations

The following section provides a simplistic overview of some important federal income tax considerations for BHS. However, we recommend that BHS engage tax counsel to review the JV structure, agreements, and organization documents should BHS move forward with this

[18] Asbahi et al., *Health Care Transactions Manual: Understanding the Consequences of the Health Care Deal*, 212, (Kim H. Looney et al. eds., 1st ed. 2020).

structure. Two primary types of JVs exist from a tax perspective: (1) whole entity JVs and (2) ancillary JVs. The former is created when the non-profit partner contributes its entire operations to the JV.[19] Here, in order to keep its tax-exempt status, BHS would need to possess majority control over the JV and ensure the JV operates solely for tax-exempt purposes.[20] Because whole entity JVs go beyond BHS's goals for an affiliation, we limit further discussion to ancillary JVs.

In an ancillary JV formed as a tax partnership,[21] the non-profit partner will not jeopardize its tax status from merely participating in the JV. However, BHS must avoid conferring non-incidental private benefits or private inurement to OAG and amassing unrelated business taxable income (UBTI).[22] Prohibited private benefits can be mitigated by ensuring fair market value for contributions to the JV and any associated service agreements. This restriction limits some of the more attractive benefits of horizontal integration, such as the ability to share assets and services at discounted rates, thereby reducing potential cost efficiencies that might otherwise be realized through a JV. Private inurement is strictly prohibited and can occur when "insiders," like executives, are provided compensation in excess of fair market value.[23] If the JV engages in activities that do not align with BHS's charitable purpose, any resulting income could become UBTI. While no strict threshold on the amount of UBTI a non-profit can generate before risking its tax-exempt status exists, minimizing such income is in BHS's best interest. The most effective

[19] Nicholas A. Mirkay, *Relinquish Control! Why the IRS Should Change Its Stance on Exempt Organizations in Ancillary Joint Ventures*, 6 NEV. L.J. 21, 23 (2005).

[20] "Whether a proposed joint venture activity furthers exempt purposes may be determined by analyzing the 'community benefit' to be achieved. Certain indicia of . . . are (1) creation of a new provider of health care services; (2) expansion of community health care services; (3) improvement in treatment modalities; (4) reduction in health care costs; and (5) improved patient convenience and access to physicians." Priv. Ltr. Rul. 9352030.

[21] A partnership is defined in the federal tax law as including "a syndicate, group, pool, joint venture, or other unincorporated organization, through or by means of which any business, financial operation, or venture is carried on, and which is not…a trust or estate or a corporation." 26 U.S.C. § 7701(a)(2).

[22] BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS & PROBLEMS, 853 (8th ed. 2018).

[23] *Health Care Transactions: Overview—Joint Ventures*, BLOOMBERG L. (last visited Feb. 5, 2025), https://www.bloomberglaw.com/external/document/XBPKTFQO000000/health-care-transactions-overview-joint-ventures.

way to mitigate this risk is to ensure that the JV's operations directly further BHS's mission by retaining a majority interest in the governance structure. At a minimum, BHS should secure veto rights over JV activities that fall outside its tax-exempt purpose, minimizing excessive UBTI.

ii. Accountable Care Organization

A JV that forms a new legal entity presents a strategic opportunity to operate as an ACO. The ACO model is intended to improve quality of care while managing costs, making it a beneficial structure for this affiliation.[24] However, qualifying as an ACO under CMS regulations requires a high level of investment, demonstration of coordinated care and shared liability for cost and quality outcomes. As a result, ACO participation represents one of the most integrated affiliation models, meaning OAG's alignment is essential for successful implementation.

Beyond cost-saving advantages, ACOs mitigate the regulatory risks so that physicians can own an equity interest in the JV and coordinate care for shared patients.[25] ACO regulations establish safe harbors that protect certain ACO activities, provided the entity adheres to stringent transparency requirements, implements robust conflict-of-interest policies, and maintains extensive documentation. However, due to ACO exclusivity rules, participants can only belong to a single ACO. Therefore, it is crucial to determine whether OAG physicians are currently affiliated with an existing ACO before pursuing this structure.

iii. JV Regulatory Risks

The Office of Inspector General (OIG) closely scrutinizes JVs. If BHS intends to proceed with a JV, further analysis of OIG advisory opinions and Loyola regulations is necessary to confirm that the affiliation aligns with AKS and AKCF safe harbors and Stark and PRTL

[24] Health Capital Consultants, *Valuation of Accountable Care Organizations: Regulatory Environment*, 16 HEALTH CAP. TOPICS, 1,1 (2023), https://www.healthcapital.com/hcc/newsletter/09_23/HTML/ACO/convert_valuation-of-acos-regulatory.php.
[25] *Id.*

exceptions. Under the AKS, JVs raise red flags when one party's primary contribution is its ability to generate or influence patient referrals. While no single factor guarantees immunity from scrutiny, JVs are generally viewed more favorably when they: (1) require venturers to make substantial capital contributions, (2) provide reasonable and proportionate returns based on contributions, (3) involve genuine business risks for all, and (4) implement safeguards to prevent the perception that participation is contingent on making referrals. Like M&A, if PSAs are necessary to secure OAG's physician services in the JV, they will be subject to the same regulatory considerations discussed below.

Stark Law presents significant challenges for JVs, as it explicitly prohibits physicians, as owners of the JV, from receiving reimbursement for DHS related to the JV, unless a specific exception applies.[26] Like AKS, PSAs also fall within a Stark exception.[27] Further, if the JV is structured as a non-profit, the physicians may not be classified as "owners," thereby falling outside of Stark Law.[28] However, if OAG is unwilling to comply with non-profit restrictions, the JV must fall within an exception to ensure compliance.

One potential exception is the "rural provider" exception, which allows physician ownership in an entity furnishing DHS in a rural area, provided that at least 75% of its DHS is delivered to rural patients.[29] As previously noted, another pathway to compliance is structuring the JV as an ACO. Furthermore, Stark has an exception for physician ownership in Rural Emergency Hospitals (REH).[30] Given BHS's goal to reinvigorate PMC, this exception grants a unique

[26] *Fraud & Abuse Laws, supra* note 13.
[27] *Stark Exception*, COLL. OF AM. PATHOLOGISTS, https://documents.cap.org/documents/stark-law-exceptions.pdf.
[28] John Fink, *Hospital-Employed Physician Owners in Ambulatory Surgery Joint Ventures*, ECG MGMT. CONSULTANTS, https://www.ecgmc.com/insights/article/1004/hospital-employed-physician-owners-in-ambulatory-surgery-joint-ventures.
[29] Christine L. Noller, *Stark Act and Anti-Kickback Considerations with Hospital-Physician Joint Ventures*, VEZINA L. GRP., https://www.vezinalaw.com/stark-act-and-anti-kickback-considerations-with-hospital-physici.html.
[30] Joseph Keillor & Kathleen R. Salisbury, *CMS Guidance on Rural Emergency Hospitals*, BAKER DONELSON (Feb. 2023), https://www.bakerdonelson.com/cms-guidance-on-rural-emergency-

opportunity for BHS and OAG to jointly own and operate the hospital if it is converted from a CAH to an REH. This possibility extends beyond the scope of this memorandum but warrants further analysis. This exception may appeal to OAG physicians and serve as a means to strengthen and formalize the affiliation between the two entities.

iv. JV Liability Assumption and Mitigation

Because BHS and OAG will remain independent entities within a JV, BHS faces minimal direct risk of inheriting OAG's existing compliance issues. However, if OAG's compliance deficiencies trigger enforcement actions, the resulting financial penalties could threaten OAG's ability to participate in the JV. Such consequences could lead to OAG's financial instability and the exclusion of its physicians from federal reimbursement programs, ultimately jeopardizing the affiliation's success. Given these risks, as well as the potential for BHS to be directly liable for compliance issues arising from the JV's activities, it is essential that BHS implement stringent governance and regulatory safeguards and maintain control over the JV's administrative and compliance functions to mitigate exposure.

Further, if the JV operates under BHS's CCN on account of favorable payor contracts or drug-related pricing programs,[31] compliance violations by the JV could have far-reaching consequences, potentially jeopardizing not only the JV itself but also BHS's broader operations. This could subject BHS to heightened regulatory scrutiny, financial penalties, or even restrictions on its participation in federal healthcare programs. To mitigate this risk, BHS should carefully evaluate whether allowing the JV to use its CCN aligns with its risk tolerance and consider other options, such as an ACO that preserves regulatory separation between the entities through a new CCN. Due to these concerns, BHS may favor structuring the JV as a limited liability company

hospitals#:~:text=Stark%20Implications&text=As%20such%2C%20the%20rural%20ownership,to%20residents%20of%20rural%20areas.

[31] *See* e.g., *340B Drug Pricing Program*, HEALTH RES. & SERVICES ADMIN. (Feb. 2025), https://www.hrsa.gov/opa.

(LLC) or other entity that offers liability protection. A LLC would ensure BHS's financial risk is limited to its investment, reducing the potential impact of compliance-related penalties or liabilities stemming from the JV's operations.

C. Contractual Affiliation

If BHS and OAG do not align on financial goals and patient care, which is instrumental to a successful JV, they may still establish a viable affiliation through contractual agreements for services. This approach could serve as an initial step toward a more integrated collaboration, offering flexibility through time-limited agreements that can be adjusted or terminated if they do not meet expectations. Various contracts may be needed to support BHS's strategic objectives. However, it is important to note that none of the proposed contractual affiliations guarantee geographic expansion beyond patients BHS would naturally gain through exposure to OAG.

i. Professional Services Agreement

PSAs allow BHS to contract with OAG for its physician and non-physician services. PSAs serve two primary purposes: they (1) enable hospitals to contract with physicians for professional services without violating the corporate practice of medicine prohibition and other regulations, and (2) grant OAG autonomy. BHS can consider two different types of PSAs: a traditional PSA or a global PSA. In a traditional PSA, (1) BHS becomes responsible for management activities, overhead, and billing the services provided by OAG's physicians and (2) BHS pays OAG's physicians' compensation based upon work relative value units (RVU).[32] In a global PSA, (1) OAG maintains responsibility for management and overhead costs, but allows BHS to bill for the services and (2) BHS makes a "global" payment to OAG for all expenses.[33]

[32] *Professional Services Agreements (PSAs) Between Physicians and Hospitals*, PYA (Jan. 8, 2025), https://www.pyapc.com/insights/professional-services-agreements-psas-between-physicians-and-hospitals/.
[33] *Id.*

As mentioned above, the PSA model allows for OAG to retain physician autonomy and even operational autonomy through a global PSA. However, BHS must recognize that many of OAG's current compliance risks stem from operational deficiencies. Given this reality, BHS may find it beneficial to assume greater oversight in this area where feasible. A PSA would also help address staffing shortages and could be leveraged to staff PMC if desired. When drafting the agreement, clearly defining the scope of services is essential to ensure compliance with ERDs, while well-structured termination clauses will help protect BHS's interests if issues arise.

ii. Management Services Agreement

A Management Services Agreement (MSA) would allow BHS to contract with OAG for management services.[34] Given OAG's operational challenges, BHS could alleviate administrative burdens in exchange for a management fee—potentially reducing OAG's incentive to seek private equity investment. While a traditional PSA limits management oversight to the specific services outlined in the PSA, an MSA would grant BHS broader authority to address OAG's compliance issues and operational inefficiencies beyond the physician services directly provided to BHS. However, serving as a quasi-Management Services Organization (MSO) could raise tax status concerns, especially if not paired with a PSA. If the IRS determines the MSA falls outside BHS's charitable purpose, it could pose adverse tax implications, including exposure to UBTI.

iii. Co-Management Arrangement

PSAs and MSAs provide structured but one-directional approaches, limiting the level of collaboration needed to achieve BHS's broader strategic goals. In contrast, CMAs are contracts that provide for shared governance, allowing for deeper collaboration on clinical and operational

[34] *Management Services Agreements (MSAs): What Healthcare Professionals Should Understand*, JACKSON LLP, https://jacksonllp.com/msa-management-services-agreements-in-healthcare/.

improvements.[35] Essentially, BHS would contract with OAG to jointly manage BHS's cancer service line. While a CMA may allow BHS to increase the quality of oncology care, this type of arrangement alone does not achieve all of BHS strategic goals because in effect BHS is just paying for OAG's clinical expertise and governance.

Liability concerns with AKS may prove challenging for BHS because CMAs are fairly new and there is minimal established regulatory guidance. Because the CMA would include representatives from both BHS and OAG managing the cancer line together, the most significant factor to consider in a CMA is whether BHS and OAG can align their visions for patient care. This alignment is not just clinical—like a JV, it extends to financial and Catholic considerations.

iv. Contractual Regulatory Risks

To best avoid AKS and Stark liability, all contractual arrangements should be structured to fall within respective safe harbors and exceptions.[36] Because CMAs are relatively new and not well-established, it is crucial to investigate whether established safe harbors and exceptions exist. Failing to do so could risk precluding the CMA option altogether, especially if there are concerns about the impropriety of OAG patients seeking BHS services—whether for the jointly managed cancer service line or for other BHS services outside of oncology. Possibly the most important aspect to consider when seeking to avoid regulatory risks is compensation—it is vital to ensure that all compensation is based on fair market value and quality, not volume or utilization, which also helps alleviate tax concerns.[37]

A key concern regarding BHS's tax-exempt status is the compensation associated with any of the agreements. To ensure compliance, the compensation structure must meet the following

[35] *Understanding Co-Management Arrangements*, SULLIVAN COTTER, https://sullivancotter.com/understanding-co-management-arrangements/.
[36] *See* 42 C.F.R. § 1001.952(d) for an example of safe harbor requirements for PSAs, including written agreements, mandatory contract length, service specification, and demonstrated necessity, in addition to FMV compensation.
[37] *See* United States *ex rel.* Drakeford v. Tuomey, 976 F. Supp. 2d 776 (D.S.C. 2013).

criteria: it (1) must not serve as a disguised mechanism for profit distribution or transform the activity into a joint venture, (2) must result from an arm's-length transaction, and (3) must be reasonable as compared with other similarly sized arrangements within the same locale.[38] These concerns can largely be mitigated through research and effective negotiation, provided that the parties are willing to set compensation at fair market value.

v. Contractual Liability Assumption and Mitigation

Similar to JVs, contracts allow BHS to minimize the risk of inheriting OAG's existing compliance issues. Because BHS and OAG remain further separated in a contractual relationship, the risks to BHS here are even more limited. However, BHS should still ensure the physicians possess malpractice insurance and negotiate indemnification provisions and exit strategies.

D. Take No Action

Although this memorandum provides BHS with a range of affiliation options, from highly integrated models to those with limited liability exposure, we emphasize that sometimes the most prudent course of action may be to take no immediate action. OAG's current regulatory risks with fraud and abuse laws are not insignificant. Additionally, regarding OAG's ability to continue serving its Medicare and Medicaid patients, it is critical to wait and see whether CMS approves OAG's corrective action plan. Further, it is necessary to complete supplemental due diligence outlined below as it may impact the viability of the options presented and uncover new liability exposure. While taking no action presents the least risk for BHS, the downside is that it may allow OAG to continue discussions with private equity, potentially resulting in a missed opportunity for a partnership.

[38] *Community Physicians Services, Inc.*, IRS Determination Ltr. (Apr. 24, 1996).

VI. SUPPLEMENTAL DUE DILIGENCE AND MISSING FACTS

Before affiliating with OAG, conducting thorough due diligence is essential. We categorize the objectives for due diligence into high and low priority but emphasize the need for a comprehensive investigation, particularly before pursuing a more integrated affiliation structure.

A. High Priority

Perhaps one of the most important objectives during due diligence will be to fully examine OAG's risk exposure to violations that jeopardize its participation in federal healthcare reimbursement programs. As mentioned, these violations are particularly costly. Similarly, because Loyola's PRTL and AKCF present similar concerns as Stark law and AKS respectively, supplemental due diligence will also need to assess whether Loyola has safe harbors and whether those safe harbors mirror federal safe harbors or if they impose additional requirements.

Additionally, BHS is concerned about recent state-level policy changes in Loyola that impact Medicaid and Medicare reimbursement. To assess whether these changes could affect the affiliation with OAG, it is crucial to understand how these changes influence reimbursement rates, coverage eligibility, and regulatory compliance. Given BHS's mission to expand rural cancer care—where a large portion of patients depend on federal healthcare programs—any risk of losing eligibility for Medicare or Medicaid reimbursement severely undermines the affiliation's viability.

Further, OAG's specific objectives, such as financial motivation, for the affiliation remain unclear. As emphasized, compensation and benefits must be structured in a way that minimizes adverse tax consequences and regulatory risks. Since BHS must adhere to the ERDs, OAG physicians will likely be required to comply with these directives regardless of the affiliation structure. Therefore, it is essential to determine whether any of OAG's existing practices conflict with the ERDs and if so, whether they are willing to modify accordingly. Finally, due to antitrust related risk, it will be necessary to conduct a comprehensive market analysis, as it could eliminate

certain affiliation options altogether. This includes evaluating market concentration, potential harm to competition, and whether the affiliation would create any undue market dominance.

B. Low Priority

Loyola's CHRA and HIPAA will need to be researched to determine what additional requirements exist for a shared IT/EHR system. Affiliation will only be successful if there is continuity of care and shared patient information. Also, OAG's and BHS's existing telehealth efforts could be improved from the benefits and incentives outlined in Loyola's RHAIA, which requires due diligence to understand how to qualify for those incentives.

Another due diligence objective will be to conduct a thorough investigation of Loyola's CPOM law. Specifically, it is essential to determine which entities are classified as business corporations and whether an exception exists for hospitals. This analysis will be crucial in assessing whether direct employment of physicians is a viable option, eliminating the need for PSAs, alleviating regulatory risks, and affording BHS more control, if OAG is willing.

Additionally, some states have Certificate of Need (CON) laws that require state agency approval to expand an existing healthcare facility's services in a certain area. If Loyola has a CON law, BHS may need to seek approval from the state's health planning agency to proceed with affiliation with OAG if an expansion of BHS's oncology services occurs.

In addition to adhering to 501(c)(3) requirements, BHS must comply with Loyola's state-specific regulations to maintain tax exemption for state income. This means conducting further due diligence to understand Loyola's state laws, which may impose additional conditions or requirements that go beyond federal standards. Similarly, since mergers are creatures of state law, BHS will need to determine whether Loyola allows for such transactions. For the JV, it is equally important to understand Loyola's entity definitions like partnership, nonprofit corporation, and LLC, which will dictate which entity structures are viable for an affiliation.

To determine whether it would be more advantageous to bill under OAG or BHS, a thorough review of each entity's payer contracts is necessary. Evaluating the reimbursement rates, network status, and contract terms will help identify which offers the most financial benefit. Similarly, OAG's contracts with pharmaceutical companies and device manufacturers may provide financial advantages if they include favorable pricing or rebates. However, these contracts must be carefully examined to ensure they do not violate state or federal laws.

OAG leases several of their clinics where landlord consent is required before a change in management or control. It is important to investigate how broadly defined "management" and "control" are to determine which affiliations require consent. At a minimum, M&A and the incorporated JV options will likely require these negotiations. Finally, BHS has identified revitalization of PMC as a top priority. To determine whether an affiliation with OAG can support this goal, it is essential to understand PMC's unique challenges. As noted in the JV option, CMS has introduced a pathway for CAHs to convert into REHs to prevent closure. A thorough assessment is needed to determine PMC's eligibility for REH and whether OAG can help address its specific operational and financial concerns.

VII. RECOMMENDATION

While this memorandum is primarily intended to provide BHS with a comprehensive overview of affiliation options and associated risk so that BHS can make the most informed decision possible, we conclude with a recommendation. Assuming OAG agrees to a thorough compliance review without guarantee of partnership—we recommend forming a JV. Of the options presented, a JV best aligns with BHS's strategic goals while still preserving OAG's autonomy.

Because a JV can be structured to shield BHS from OAG's pre-transaction liabilities and, to a large extent, post-transaction compliance risks, its primary caveat is the need for significant

alignment. This alignment becomes even more critical if BHS and OAG pursue an ACO, which—if successful—could help alleviate financial burdens and enhance care coordination. Thus, if BHS determines that OAG does not have the financial stability or shared vision for patient care necessary for a successful JV, other affiliation options should be reconsidered. Specifically, contractual affiliations could serve as a trial run, the success of which could build trust and form alliances necessary to move towards a more permanent structure.

While a JV offers the best balance between strategic alignment and risk mitigation, this recommendation hinges on the severity of OAG's potential violations of federal and state healthcare reimbursement program requirements. If OAG's compliance issues are severe enough to lead to exclusion, we recommend that BHS refrain from pursuing an affiliation. Once supplemental due diligence is complete, we will have a more comprehensive understanding of the risks and can provide a more detailed affiliation proposal for BHS and OAG.

VIII. CONCLUSION

Any of the four proposed affiliations could help BHS achieve its goal of reinvigorating its rural markets and providing more comprehensive cancer care for its patients. Overall, BHS should consider the regulatory and liability concerns as well as strategic, cultural, and operational considerations prior to determining which affiliation structure best serves their goals.