



Challenges to Tax-Exempt Bonds

2016 NAHEFFA Conference | September 29, 2016

Nancy A. Burke, Chapman and Cutler LLP

Michael A. Boisvert, Longhouse Capital Advisors, LLC

Jennifer Russano Koltse, Chapman and Cutler LLP

 **Longhouse**
CAPITAL ADVISORS

Chapman and Cutler LLP
Attorneys at Law • Focused on Finance®

Alternative Financing Options

Nancy A. Burke
Chapman and Cutler LLP



Why Alternative Financing Options Continue to Grow

- Interest Rates
- Tax Law Restrictions
- Credit Stability
- Market Stability
- Regulatory Changes
 - Bank Regulations
 - SEC Regulations
- Other

Financing Alternatives: Direct Purchases

Advantages to Borrowers

- Simplicity of bank providing direct funding to borrower through a negotiated financing
- Insulates borrower from the risk of downgrade of credit enhancer/liquidity provider
- Avoids volatility of the capital markets
- Eliminates costs of an underwriter and remarketing agent (and their counsel) and generally does not require an offering document
- Larger pool of banks can participate since rating of credit enhancer/liquidity provider is no longer a factor
- Provides flexible long-term financing when structured within the context of a multi-modal Indenture

Advantages to Banks

- Eliminates the contingent liquidity risk inherent in credit facilities and liquidity facilities
- Results in a funded loan not subject to “liquidity coverage ratio” under Basel III
- Results in tax-exempt income to the bank
- Provides another way to deploy large and relatively inexpensive deposit base
- Can be closed more quickly than a letter of credit transaction

Financing Alternatives: Taxable Bonds

- 501(c)(3) organizations issue bonds to the market directly
- Option to finance projects that would not otherwise qualify for tax-exempt financing
- Generally require a significant issue size
- Available to a limited number of borrowers
- Make-whole redemption provisions

Financing Alternatives:

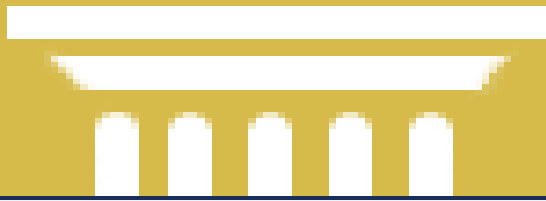
New Markets Tax Credit

- Credit for equity investment in community development entities (“CDEs”) — a CDE is a domestic corporation or partnership whose mission is serving or providing investment capital for low-income communities or persons that remains accountable to residents of low-income communities
- At least 85% of the CDE capital must be loaned or invested in qualified low-income community investments
- Aimed at development in low- and moderate-income areas
- 39% tax credit over 7 years
 - 5% of invested amount (years 1-3)
 - 6% of invested amount (years 4-7)
- Investment must remain for 7 years
- Credit subject to 100% recapture if noncompliance
- 6 month cure period

Financing Alternatives:

Social Impact/Pay for Success Financings

- Pay for success financing — also known as “social impact bonds” or “SIBs” — can enable policymakers to use resources more efficiently and improve services for disadvantaged populations, while at the same time providing socially-minded investors with attractive investment opportunities
- Stakeholders include government agencies, service providers, investors, communities and people in need, and intermediaries who structure and manage the transaction
- Investors provide the working capital necessary for an intermediary to hire and manage service providers, and a third-party evaluator determines whether the desired outcome has been achieved
 - If the program succeeds, the government releases an agreed-upon sum of money to the intermediary, which then repays its investors with a return for taking on the upfront risk
 - If the program fails, the government is not on the hook and the investors do not get repaid with public funds



Presentation to:

2016 NAHEFFA Conference:

USDA Community Facilities Loans:

Overview and Opportunities for Conduits

September 29, 2016

Table of Contents

	<u>Page</u>
• Overview	9
• Acquisition Finance Model	10
• Components of Application to USDA	12
• Other Requirements / Features of the Loan	13
• Opportunity for Conduit Issuers	14
• Latest Developments	15

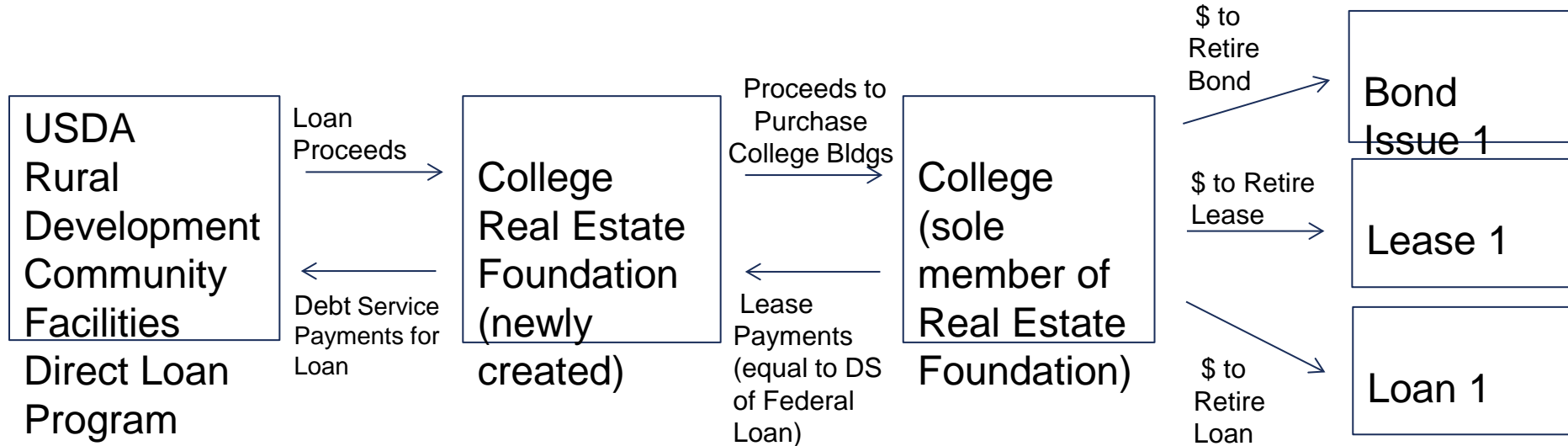
Overview

- The USDA's Rural Development Community Facilities Program has been making and guaranteeing loans for rural hospitals, colleges and non-profits for over 20 years.
- Lending programs aimed at communities under 20,000 in size.
- Historically, both direct loan and guarantee programs limited by:
 - Amount of funds available
 - Necessity of twinning very attractive Direct Loan program (where USDA itself is the lender) with less attractive Guaranteed Loan program (where banks provide somewhat higher rate loans that are 90% guaranteed)
 - Limitations on refinancing – no more than 50% of overall financing
 - Reputation for long lead times in completing financings
- Recent developments have led to renewed interest in the financing:
 - 700% rise in Direct Loan Fund availability over past 5 years. \$2.3 billion now available.
 - Recently approved “**Acquisition Finance**” approach allows greater flexibility in refinancing debt via sale-leaseback model. **Acquisition Finance reserved for colleges only.**
 - USDA 40-year, Direct Loan Rate has dropped from 3.625% in Summer of 2015 to 2.375% for Winter 2016.

Acquisition Finance Model

- The USDA “Acquisition Finance” approach
 - Involves a new sister LLC entity being formed by the College or University
 - LLC structure has varied from state to state
 - In Iowa, an LLC or “Foundation has been closely-held, College is single member of the LLC and President, Board Chair, CFO and two others have formed LLC Board
- The LLC borrows from USDA, using loan proceeds to buy mortgaged properties from the College
- LLC leases properties back to College. Payment equals debt service on LLC’s loan.
- College then uses the proceeds of the sale to the LLC to pay off its prior debt (bonds, loans, endowment loans, etc)
- Some of these financings have also included an “Additional Acquisition Proceeds” line item in addition to the debt payoff which can fund other College needs.
- Sample Acquisition Financings LCA has worked on:
 - Completed: William Penn Univ. (\$44 mm), Upper Iowa University (\$71 mm)
 - In process: Iowa Wesleyan (\$26 mm), Central Coll. (\$64 mm), Maharishi Univ. (\$12 mm)

USDA Acquisition Finance Model



Components of Application to USDA

- Applicant Statement
- Feasibility Study by Consultant with examined opinion – 5-year operating and balance sheet projections, Debt Service Coverage Ratios, assurances that other financing sources will not provide the same restructuring benefits.
- Letter of Support from Local, State officials.
- Appraisal and Title work – Target of 1:1 loan to value
- Environmental Study – Modest, less onerous than a typical Phase 1
- Foundation documents – Resolution of College to Form Foundation LLC, Operating Agreement, Lease Agreement, Certificate of Organization. Foundation closely held and rolls up into College's audit. Foundation Board typically includes College President, CFO and 3 members of the College's Board of Trustees.
- Public Meeting of Foundation to seek USDA Assistance
- Signoff from U.S. Department Office of General Counsel
- Approval from up to 3 USDA levels depending on loan size: sub-state (regional), state level and national level.

Other Requirements / Features of the Loan

- True fixed rate financing, with final maturities of up to 40 years
- Debt Service Reserve Fund equal to one year's debt service.
- Relatively light covenants:
 - Debt Service Coverage Ratio, 1.0X or 1.1X
 - Additional Debt with consent of USDA. Additional debt can be issued on parity.
- USDA loans in comparison to tax-exempt debt:
 - Similar restrictions against funding sectarian facilities
 - No post-issuance compliance requirements, as in tax-exempt debt
 - USDA loan costs of Issuance somewhat less
 - Amortizations less flexible – monthly level debt service amortizations only, after limited interest-only periods
 - Longer financing time -- 4-6 months or more vs. 2-3 months for tax-exempt
 - “Mission” element of USDA financing approval process may allow tougher “turnaround” stories to get done on better terms than in the tax-exempt market

Opportunity for Conduit Issuers

- Once USDA loan approved, Borrower has **up to 5 years to access and close the loan.**
- Some Borrowers have chosen to **postpone closing** and use lower cost, tax-exempt **interim financing.** Interim financing is secured by the promised USDA loan takeout.
- Example: Upper Iowa University (UIU):
 - In early August of 2016, UIU received from USDA a “Letter of Conditions” (essentially a commitment letter) for its **2.75%, 28-year Direct Loan**
 - On the strength of this Letter, UIU undertook to do an interim Note financing and received Moody’s highest Mig-1 ST rating
 - On 8-17-2016, Raymond James underwrote \$71 mm of tax-exempt notes issued by IHELA for UIU at a **2-year rate of 1.0%.** These notes were used to refinance the University’s debt, with an overall PV savings % exceeding 14%.
 - PV savings for the refinancing were boosted by the 1.75% in rate savings for the next two years vs. a situation where the USDA loan was taken down immediately.
 - The Series 2016 Notes will be taken out by the LLC’s USDA loan when it closes in two years. At that time the sale leaseback of campus buildings will be finalized.

Latest Developments

- Another \$2.3 billion in USDA Direct Loan Authorization approved for FY 2017
- Not unexpectedly, the drastic drop in rates has energized a new set of Borrowers. Applications have soared.
- USDA is rationing the demand for new loans by:
 - Giving priority to non-Acquisition Finance loans with new money elements (greater jobs multiplier)
 - Asking Borrowers to blend into the overall plan financing from the under-utilized, bank-based USDA Guaranteed Loan program, or other sources of financing
- In more recent plans of finance that LCA has worked on, the requirement for guaranteed loan percentage has been between 10% and 20% of the overall financing need.
- Rates for these Guaranteed loans range from 3.25% to 4.5%, depending on the borrower's credit and the tenor of these loans. Loans must be committed for the same period of time as the Direct loan, but can have rate resets prior to maturity.

Clinical Integration in Health Care Delivery: Legal Challenges

Jennifer Russano Koltse
Chapman and Cutler LLP



Overview

1. ACOs and Clinically Integrated Networks — A Primer

- The Concept
- In Practice
- The Numbers

2. Potential Legal Barriers to Clinical Integration

- Tax-Exemption Considerations
- Fraud and Abuse Considerations
 - Stark
 - Anti-Kickback

3. Going Forward

ACOs and Clinically Integrated Networks: The Concept

- One of the goals of Health Care Reform – to reduce the cost of health care spending – triggered clinical integration
- Cost reduction requires the development of alternative payment models, which directly corresponds with higher levels of clinical integration:
- In order to reduce costs, the industry is transitioning from volume-based reimbursement (FFS reimbursement) to value-based reimbursement (reimbursement is tied to quality outcomes and cost savings rather than the number of procedures or services performed)
- The new reimbursement model demands accountability for the health of a patient beyond admission, outpatient procedure, or an office visit — a responsibility that only can be achieved only if hospitals, physicians and other professionals work as a team with common goals and aligned incentives
- AMA describes clinical integration as the means to facilitate the coordination of patient care across conditions, providers, settings, and time in order to achieve care that is safe, timely, effective, efficient, equitable, and patient-focused

ACOs and Clinically Integrated Networks: In Practice

- In practice, clinical integration takes many forms ranging from simple care coordination efforts for a clinical condition, such as developing care teams for diabetes patients, to the formation of large-scale health systems that employ physicians
 - “Vertical integration” refers to the coordination of the delivery of care within a single organization (such as a hospital).
 - “Horizontal integration” refers to the coordination of care across organizations (such as between a hospital and a local physician group)
- Accountable Care Organizations (“ACOs”) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to the Medicare patients they serve
 - Medicare Shared Saving Program ACO
 - Private Payor accountable care organizations/networks

ACOs and Clinically Integrated Networks: The Numbers

- Industry trends predict that value based purchasing programs, including programs that condition reimbursement on patient outcome measures, to become more common and to involve a higher percentage of reimbursement amounts
- CMS announced goal of tying 30% of traditional Medicare payments to quality or value through alternative payment models such as accountable care organizations, bundled payment arrangements or integrated care demonstrations by the end of 2016, and tying 50% of payments to these models by the end of 2018
- CMS announced its 30% goal was reached almost a year ahead of schedule, evidencing a rapid volume-to-value evolution within the Medicare program
- As of the end of January 2016, reports show 838 active public and private ACOs (up from 64 in 2011), across all 50 states
[<http://healthaffairs.org/blog/2016/04/21/accountable-care-organizations-in-2016-private-and-public-sector-growth-and-dispersion/>]

Tax-Exemption Considerations

- The ability of tax-exempt hospitals to participate in ACOs and other clinically integrated networks depends on whether participation allows the hospital to further charitable purposes with the meaning of Section 501(c)(3) without generating more than incidental private benefit
- Failure to meet that standard can result in UBIT, loss of exemption for interest on bonds and loss of tax-exempt status
- To date the IRS has confirmed only that participation in an ACO that is limited to the MSSP is consistent with the requirements for exemption as a Section 501(c)(3) organization (IRS Notice 2011-20 and the IRS ACO Fact Sheet (October 20, 2011))

Tax-Exemption Considerations

- In April 2016, the IRS released a denial of a 501(c)(3) exemption application for an ACO outside of the MSSP – IRS not yet persuaded that private benefit to physicians from integrated contracting is only “incidental” to the community benefits of pursuing better care and better health for patients at a low cost (PLR 201615022)
- Ruling demonstrates the challenges that a non-MSSP ACO will face in qualifying for Section 501(c)(3) status.
- Potential implications for Section 501(c)(3) organizations that currently participate in non-MSSP ACOs through LLCs or partnerships:
 - Income received from ACO may be subject to UBIT.
 - Potential for impermissible private use if ACO activities are taking place in, or ACO participants have special privileges at, facilities financed with tax-exempt bonds unless a safe harbor applies.
 - If the ACO activities become a substantial part of the section 501(c)(3) organization's overall activities, participation in the ACO also could jeopardize exemption under the IRS's current approach.

Fraud and Abuse Considerations: Gainsharing CMP Amended [42 USC § 1320a-7a]

- The Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") remedied one fraud and abuse law barrier to implementation of clinical integration payments models: the Civil Monetary Penalties Law "gainsharing" restriction
- The CMP gainsharing restriction subjects hospitals that "knowingly [make] a payment, directly or indirectly, to a physician as an inducement to reduce or limit services" to Medicare beneficiaries to civil monetary penalties
- The OIG of HHS consistently interpreted the gainsharing CMPs to apply to any reduction in services, not just reductions in medically necessary services; the gainsharing CMP did not take in account whether the change was good medical practice or had no adverse effect on a patient's care
- MACRA revised the law to make clear that the gainsharing CMP penalty was intended only if a hospital made payments to a physician to reduce or limit *medically necessary* care
- MACRA should create significant new opportunities for aligning the financial interests of hospitals and physicians and bring added stability and certainty to existing gainsharing arrangements
- However, other fraud and abuse barriers still exist...

Fraud and Abuse Considerations :

Stark Law [42 USC § 1395nn]

- The Stark Law controls when a physician may make referrals to a hospital with which she has a financial relationship
- Prohibits physicians from referring patients to receive “designated health services” (“DHS”) payable by Medicare from entities with which the physician or an immediate family member has a financial relationship, UNLESS an exception applies
- The Stark Law is a strict liability statute – any violation is subject to return of any amount paid by the Medicare or Medicaid programs for services provided to a beneficiary based on a physician’s “self-referral.” In addition to CMPs, False Claims Act liability and federal program exclusion may be imposed.

Fraud and Abuse Considerations :

Anti-Kickback Law [42 USC § 1320a-7b(b)]

- The Anti-Kickback Statute (“AKS”) prohibits the exchange of remuneration (*i.e.*, anything of value provided by a hospital) intended to influence a physician’s ordering of services or purchase of items paid for by a federal health care program
- “Safe Harbor” protection is afforded certain arrangements that meet strict requirements set forth in regulation
- AKS is a criminal statute — anyone who knowingly and willfully receives or pays anything of value as an incentive to influence the referral of federal health program business can be held accountable for a felony, subject to large fines and penalties, and possible federal program exclusion

Fraud and Abuse Considerations :

Key Challenge

- Hospitals may not be able to safely implement incentive programs for physicians unless the collaborative arrangement meets a Stark Exception and AKS Safe Harbor or other waiver
- MSSP waivers exist, but they do not apply to commercial arrangements
- Core requirements for Stark Exception and AKS Safe Harbors are not in sync with clinical integration models that reward value and outcomes
 - *e.g.*, Stark and AKS barriers may exist with respect to:
 - Shared infrastructure to coordinate care
 - Incentives for care redesign to improve outcomes
 - Incentives for more efficient treatment options
- Advisory opinion process exists for each law, but process is long, expensive and only applies to the requestor

Michael A. Boisvert



Michael Boisvert is the founder and president of Longhouse Capital Advisors. He has over 25 years of investment banking and financial advisory experience serving the capital needs of public and private universities, private K-12 schools, YMCAs, cultural institutions and social service organizations. Prior to founding Longhouse Capital Advisors, he headed up the National Higher Education and Non-Profit Financing practice for BMO Capital Markets and for Griffin, Kubik, Stephens & Thompson, Inc.

Among his higher education clients are Elmhurst College, Upper Iowa University, Lewis University, the University of St. Francis, Grand View University, Wartburg College, Simpson College, Northern Illinois University, West Virginia State University, the St. Louis College of Pharmacy, Missouri Baptist University, and William Penn University.

Prior to working as an investment banker, Mr. Boisvert served as Executive Assistant to the Governor of Nevada and as Campus Planner for Cranbrook Educational Community. Mr. Boisvert received his Bachelor's in Public Affairs from the University of Chicago, holds a Master's degree in Public Affairs and Urban and Regional Planning from Princeton University and an MBA from Columbia University.

Longhouse Capital Advisors, LLC
628 N. Kensington Ave.
La Grange Park, IL 60526

630.926.9509
michael@longhousecapital.com

Nancy A. Burke



Chapman and Cutler LLP
111 West Monroe Street
Chicago, IL 60603

T: 312.845.2953
F: 312.516.33953
burke@chapman.com

Nancy Burke is a partner and the Co-Practice Group Leader of Chapman's National Public and Health & Education Finance Department.

Nancy has been practicing law since 1987 when she joined Chapman and Cutler. She has devoted substantially all of her time to the field of tax-exempt and taxable bond financings for healthcare, educational, and cultural institutions. She serves as bond counsel, disclosure counsel, underwriter's counsel, and special corporate counsel.

Nancy has worked on a wide range of tax-exempt and taxable financings throughout the country, and has served as bond counsel and disclosure counsel to state authorities, cities, villages, and counties. Among others, she has served as bond counsel, underwriter's counsel, or special corporate counsel on bond issues for the benefit of Advocate Health Care Network, The University of Chicago Medical Center, the Rehabilitation Institute of Chicago, Providence Health System, Mount Sinai Medical Center, NorthShore University Health System, OSF Healthcare System, Northwestern University, The University of Chicago, Loyola University of Chicago, DePaul University, University of Notre Dame, Chicago Symphony Orchestra, Museum of Science and Industry, The Shedd Aquarium, The Adler Planetarium, and the Field Museum of Natural History.

In September 2013, Nancy was elected a Fellow of the American College of Bond Counsel.

In addition to her extensive client representation, Nancy is a regular speaker at industry conferences and client in-house seminars on 501(c)(3) finance, capital campaign issues, private use issues, disclosure matters, and post-issuance compliance.

Jennifer Russano Koltse



Chapman and Cutler LLP
111 West Monroe Street
Chicago, IL 60603

T: 312.845.3707
F: 312.516.3902
koltse@chapman.com

Jennifer Russano Koltse is a partner in Chapman's National Public and Health & Education Finance Department and Commercial Lending Group. She focuses her practice on advising lenders and healthcare providers and businesses regarding federal and state healthcare issues that arise in the context of lending transactions, mergers and sales, and affiliations and joint ventures, including:

- Stark and Anti-kickback compliance
- HIPAA compliance
- Corporate practice of medicine and fee-splitting prohibitions
- Medicare, Medicaid and other third-party reimbursement matters
- Clinical integration and healthcare reform efforts
- Tax-exemption matters

Jennifer has provided guidance in financial and strategic transactions involving a wide array of healthcare providers and businesses, including: hospitals and health systems, nursing homes and assisted living facilities, clinical labs, pharmacies, ambulatory surgery centers, urgent care clinics, behavioral health and physical therapy providers, managed care organizations, and accountable care entities. Her experience includes the management of due diligence and compliance reviews and the negotiation and drafting of transaction documents, financing instruments, and public disclosure documents related to multimillion-dollar commercial lending transactions and taxable and tax-exempt bond financing transactions.

Prior to joining Chapman in 2015, Jennifer worked as Counsel in the healthcare group of McGuireWoods, Associate in the healthcare group of Jones Day and Associate General Counsel at Presence Health, a large healthcare system.

This document has been prepared by Chapman and Cutler LLP attorneys for informational purposes only. It is general in nature and based on authorities that are subject to change. It is not intended as legal advice. Accordingly, readers should consult with, and seek the advice of, their own counsel with respect to any individual situation that involves the material contained in this document, the application of such material to their specific circumstances, or any questions relating to their own affairs that may be raised by such material.

© 2016 Chapman and Cutler LLP