Matthew A. Aiken, Esq.

Daniel F. Murphy, Esq.

Balch & Bingham LLP

Birmingham, AL

Introduction

Although not a new phenomena, physician ownership of hospitals1 has recently attracted enormous attention from a variety of stakeholders, most notably (1) hospitals seeking to improve quality of care, enhance clinical integration and improve their balance sheets; (2) physicians looking to offset declining income with sound investments in a business they understand and can monitor; and (3) regulators concerned about overutilization and corrupt medical decision-making. Physician Hospitals of America, a trade group representing physician-owned hospitals, estimates that approximately 125 hospitals in the United States are at least partially owned by physicians.2 Unless Congress takes action that would prevent such physician ownership, such as the recently proposed amendment to the Stark Law hospital ownership exception contained in the original House of Representative's version of the state children's health insurance program ("SCHIP") reauthorization bill (H.R. 3162),3 it is likely that physicians and hospitals will continue to pursue such arrangements. Proof of these prevailing winds can be found in the dozens of physician-owned hospitals that have commenced construction across the country4 since the Centers for Medicare & Medicaid Services' ("CMS") moratorium on issuing provider numbers to specialty hospitals expired in 2006.[5]

Despite the buzz surrounding physician ownership of hospitals, the trade literature has focused almost exclusively on the policy aspects of such ownership: Is it a good thing or a bad thing? Rather than attempting to join the policy debate, this article is aimed at answering some practical questions about the offering of hospital ownership to physicians (referred to in this article as a "Syndication"). Although this article focuses on issues encountered primarily in syndicating hospitals that are going concerns, the concepts addressed are also relevant to de novo hospital development and investment in Syndications by physician investors. By the end of this article, readers should understand the regulatory framework that applies to a Syndication, the key practical concerns that need to be addressed in a Syndication, and the primary transactional components that comprise a Syndication.

Planning for a Syndication

Syndications are expensive, time consuming and sometimes operationally disruptive. Thus, the golden rule of any Syndication (as with carpentry) is to measure twice and cut once. This requires evaluating the business case and all applicable regulatory requirements before committing to a Syndication. Below are some of the more important issues to tackle early in the process.

Decide What Corporate Form to Use for the Syndication

Absent physician ownership, hospitals are often organized as corporations which, for various reasons, are not the optimal vehicle for a Syndication. Because of preferable tax treatment and enhanced structural flexibility, limited partnerships and limited liability companies are preferable to corporations when hospitals are to be owned in whole or part by physician investors. Consequently, Syndications of existing hospitals are often preceded immediately by a corporate entity conversion, which raises a number of important issues. Some states statutorily authorize direct entity conversion without the legal fiction of an intermediate merger step.6 In other states, the original legal entity does not survive after a conversion and the converted entity is legally a new company.7

Depending on the state in which the Syndication occurs, the legal entity conversion requirements may require the hospital entity to obtain a new tax identification number ("TIN"). Under Medicare's change of ownership ("CHOW") rules, a change of ownership occurs when a provider changes its TIN,8 which may result in payment delays. However, in the more typical case, a change of information ("CHOI") filing will be triggered by the Syndication, rather than a CHOW, and thus the hospital can continue to bill Medicare without interruption.9

State Medicaid laws and regulations should also be reviewed to determine whether an entity conversion will necessitate notice, a change of ownership application or a new provider enrollment application to be filed with the state Medicaid agency. In addition, if the Syndication will involve an entity conversion, third party payor contracts should be reviewed to determine what notice, if any, would be required under the contracts due to the entity conversion. Third party payors may require the hospital to obtain consent to continue under the terms of the existing contract following an entity conversion. In many cases, the assignment provision in third party payor agreements will treat an entity conversion as an assignment of the agreement to the newly converted entity that would be prohibited absent consent from the payor.

Evaluate Existing Lines of Business and Determine if a Spin-Off is Required

The Stark Law10 prohibits physicians from making referrals for designated health services ("DHS"), including hospital inpatient and outpatient services,11 paid in whole or in part by Medicare and other federal healthcare programs to entities with which the physician (or a family member) has a financial relationship. The Stark Law also prohibits the entity receiving a prohibited referral from seeking payment under any federal healthcare program for the services rendered. Because compliance with the Stark Law is mandatory, a Syndication must satisfy an exception to the Stark Law. Typically, hospitals will rely on the so-called "Whole Hospital Exception"12 to achieve Stark Law compliance.13

The Whole Hospital Exception requires that the referring physician owner (1) have a financial interest in the whole hospital, and not merely a distinct part; (2) be authorized to perform services at the hospital (i.e., be a member of the medical staff); and (3) be expected to actually perform services at the hospital.14 The Secretary of the Department of Health and Human Services has made clear that the Whole Hospital Exception does not apply to referrals by a physician owner in a hospital to any hospital-based healthcare service that does not meet the Medicare conditions of participation for hospitals, 15 including wholly owned home health agencies ("HHAs") and skilled nursing facilities ("SNFs").16

Thus, any hospital that has one or more business lines that does not meet the Medicare conditions of participation for hospitals has only two options: (1) prohibit physician investors from referring patients to such line of business subsequent to closing the Syndication, or (2) legally separate such line of business from the hospital. Neither of these options is ideal. The first option is operationally complex and very difficult to police. The second option requires a restructuring of the hospital's organization and can cause additional transaction expense, reimbursement delays and cash flow disruption.

For example, if a hospital were required to divest an existing HHA, the following key transactional and regulatory steps would be required effective as of the date the physician owners are admitted as partners (or members) to the entity that owns the hospital:

• Transfer, assignment and assumption of HHA assets from the hospital entity to another entity wholly owned by the hospital's general partner or managing member;

• Consent of equity owners of the entity that owns the hospital to the HHA divestiture;

• CHOW filing with Medicare for the HHA provider number;17

• Termination of the existing HHA license and application for a new license;

• Space sublease between the entity that owns the hospital and the entity to which the HHA assets are transferred with respect to the HHA; and

• Shared services agreement between the entity that owns the hospital and the entity to which the HHA assets are transferred with respect to the HHA.

Due to the possibility in any Syndication that too few or no investors will choose to purchase ownership in the offering, the hospital should consider delaying divestiture of any of its constituent parts to comply with the Whole Hospital Exception until it can ensure a successful Syndication. A common method for achieving this is to hold physician ownership in escrow until one or more conditions subsequent are met, such as regulatory approval, the purchase of a minimum amount of hospital ownership, or other event.

It is important to coordinate state law change of ownership or re-enrollment requirements with the timing of the Medicare CHOW. In many cases, issuance of a health facility license necessitates a physical site survey by the applicable state agency that can take a significant amount of time to schedule and complete. The divested health provider may not bill Medicare until the fiscal intermediary or carrier issues a "tie-in" notice, and the "tie-in" notice cannot be issued until the divested entity receives a valid license from the state. The state licensing body timelines therefore affect the Medicare CHOW processing timeline.

Although a divested entity will typically be able to bill retroactively to the effective date of the CHOW upon receipt of the "tie-in" notice, the entity will be required to hold claims for services provided prior to receipt of the notice. Assuming that the divested entity fulfills all licensure and Medicare requirements, the entity will not experience a loss of revenue due to processing time. Instead, any processing delays would result in cash flow reductions for the period during which the provider must hold claims.

Assess Filing Requirements Early

State regulatory filings can often prove the rate-determining step in Syndication transactions. Consequently, careful review is required to assess whether the state in which the hospital is located has a certificate of need ("CON") statute,18 and, if so, whether the Syndication will trigger either (1) a notice requirement to the relevant state agency; (2) a determination that the Syndication does not require a CON; or (3) a new CON. Some states may require notice or some form of agency review if the Syndication constitutes a change of ownership under state law. If the Syndication triggers a CON agency review, be prepared for substantial delay and expense.

As in the case of state CON laws, review of applicable state licensure rules is necessary to determine whether the Syndication will require notice, agency review or a new license. Depending on the specific hospital, a review of the laws and regulations governing licensing for acute care hospitals, surgical and specialty hospitals, inpatient rehabilitation hospitals, outpatient rehabilitation clinics, HHAs and SNFs may be required.

Check with the CFO Before Printing the Offering Memorandum

Development and strategic planning personnel occasionally get out ahead of their counterparts in finance when planning a Syndication. The better practice is to establish buy-in with the chief financial officer and other key internal decision-makers before talking with physicians and others about a potential Syndication. Key questions to ask include: (1) whether the transaction is financially accretive; (2) whether capital expenditures will need to be made in advance of the Syndication; (3) whether potential physician owners will be required to guarantee a portion of the hospital's debt; (4) whether co-ownership will trigger the loss of the parent company's ability to consolidate the hospital's earnings; and (5) whether the transaction will have an impact on reimbursement or cash flow.

Defining the Rules of Engagement

It is hard to understate the impact co-ownership has on physician-hospital relations. Physicians and hospitals have always enjoyed a unique relationship that is unlike typical business arrangements. But co-ownership, and all that goes with it, increases relational complexity exponentially. Consequently, it is imperative to define the rules of engagement, in writing, in advance of the Syndication. Expectations about the key issues must be communicated to prospective investors, and the following points should be covered.

Define the Process for Getting In

What are the qualifications of the physicians that will be asked to participate in the Syndication? This question cannot be asked in the abstract, as certain regulatory guidelines apply. For example, the Whole Hospital Exception requires that physician owners of a hospital be authorized and actually expected to perform services at the hospital.19 Thus, a physician investor must be able to perform medical procedures that are typically performed at the hospital. Admitting a physician investor who specializes in an inapplicable medical field could jeopardize the availability of the Whole Hospital Exception. Similarly, the federal Anti-Kickback Statute ("AKS") prohibits any knowing or willful solicitation or acceptance of any type of remuneration to induce referrals for health services that are reimbursable by the federal government.

Consequently, no selection criteria can be based on previous or expected volume of referrals, items or services furnished, or business generated from a potential physician investor.20 Finally, the Securities Act of 1933, as amended (the "Securities Act"),21 sets out eligibility requirements for private investors which, if not met, trigger significant disclosure obligations on the part of the issuer.

The practical result of all this is that the documentation for the Syndication (e.g., the offering memorandum and subscription agreement) needs to define in advance (1) investor eligibility requirements; and (2) the key provisions of the governing document for the entity (e.g., the operating agreement or limited partnership agreement). In addition, the Syndication documentation must provide a mechanism for certifying continuing compliance with the eligibility requirements and set penalties for noncompliance. A typical subscription agreement will include representations and warranties by the investor that he, she or it:

• satisfies securities law investor eligibility requirements;

• has not borrowed any funds for purchasing the equity interest from the hospital or any of its affiliates;

• has not been excluded from any federal healthcare programs or been convicted or investigated under federal or state fraud and abuse laws;

• will treat patients insured by federal healthcare programs in a non-discriminatory manner;

• will fully disclose his, her or its investment interest to patients treated at the hospital;22 and

• is and will remain a member in good standing of the hospital's medical staff.23

Likewise, as a best practice, a typical governing document should include the following provisions:

• restrictions on the transferability of equity to any investor that cannot meet the securities and healthcare representations and warranties contained in the subscription agreement;

• a right of first refusal granted to the general partner or managing member if the physician or medical group investor wishes to sell his, her or its interest; and

• annual certification requirements that the investor has complied with healthcare regulatory requirements during the past year, including membership in good standing on the hospital's medical staff, no loss or suspension of medical license or privileges at other healthcare facilities, and no violation of fraud and abuse laws.

Decide Whether the Hospital Will Allow Investment by Physician Groups

A common question we see in Syndications is whether a hospital should sell to individual physicians only, to physician groups, or both. Putting aside the governance issues that arise when dealing with large physician groups as opposed to individuals, there are several special considerations that apply to physician group participation in Syndications that must be analyzed.

Under the Stark Law, when a group practice purchases equity in a hospital, a financial arrangement is created between its individual physician owners and the hospital. Prior to publication of the Stark Phase III final rule, it was unclear whether the individual physician owners of the group practice would be required to comply with an ownership exception24 to the Stark Law, or whether the intermediary group practice entity gave rise to an indirect compensation or ownership25 relationship between the hospital and the individual physicians. Under the Stark Phase I and II rules, the relationship between a physician member of a group practice and an entity with which the group practice had a financial relationship did not constitute a direct compensation relationship between that physician and the entity.26 Rather, the physician relationship with the third party entity previously would have been evaluated as an indirect compensation relationship.27

The Stark Phase III final rule, however, clarifies that a physician owner of a group practice entity will "stand in the shoes" of that entity for purposes of analyzing relationships between a DHS entity and the individual physician.28 Therefore, in a Syndication involving group practice ownership, the financial relationship between each physician member and the hospital must be analyzed under the more stringent requirements of a Stark Law direct ownership exception.

Treating each physician member of a group practice as a direct owner of the hospital entity has several practical implications on the timing and monitoring requirements of a Syndication. First, effective as of the date the group practice is admitted as an equity owner of the hospital, each member of the practice must be admitted to the hospital's medical staff. Due to the length of time required to process credentials for "active" medical staff membership, a hospital may be required to admit a practice group member to an interim category of medical staff membership, such as "temporary" or "courtesy," while the full credentialing process runs. Second, all members of the group practice must be actually expected to perform services of the type offered at the hospital. Finally, admission of a group practice to hospital ownership creates a need for ongoing monitoring of the membership of the group practice.

To ensure compliance with the Whole Hospital Exception, a hospital should require any group practice to report new partners, members, shareholders or employees of the practice so that each such physician may be properly credentialed at the hospital prior to joining the "physician organization" as defined in Stark Phase III.29 Significantly, the Stark Phase III final rule clarifies that employees of a physician group practice "stand in the shoes" of the organization equally with the equity owners. The governing document and the subscription agreement for the investing group practice can be used as mechanisms to require (1) prior notice to the hospital of admission of new physicians as owners or employees, (2) admission to the hospital's medical staff as a condition of admission to the group practice, and (3) certification by the group practice that all of its physicians provide services of the type offered in the hospital.

Furthermore, as both a best practice and to ensure Stark Law compliance in light of the new "stand in the shoes" regulation, the individual physician members of the group practice should be required to enter into a member's agreement to which the group practice and the hospital entity are parties. The member's agreement serves to bind each physician personally, as opposed to merely indirectly through the obligations of the practice, to requirements contained in the hospital's governing document. Most importantly, the member's agreement should require each physician member of the practice to either comply with the following requirements or divest his

or her equity interest in the practice: maintenance of medical license and medical staff privileges at the hospital; compliance with federal and state fraud and abuse laws; compliance with noncompetition provisions in the hospital's governing document; notification of financial relationships, other than the practice's interest in the hospital, between the physician and the hospital or its general partner (or managing member); and annual certification of personal compliance with provisions of the hospital's governing document. Under the member's agreement, the group practice should also represent and warrant to cause its members to comply with the hospital's governing document and the member's agreement.

Define the Process for Getting Out

Perhaps more important than deciding how to get in is deciding how to get out. This issue can be subdivided into two areas: (1) procedures for repurchasing ownership following certain trigger events; and (2) procedures for unwinding the entity in the event of a vote of the owners or some change in law. The governing document needs to clearly identify the circumstances under which a physician owner may or must sell his or her interest back to the entity, or to one or more designated co-owners. Mandatory resale events could include loss of medical license or staff privileges at the hospital or other healthcare facilities, violation of healthcare fraud and abuse laws, violation of noncompetition restrictions, bankruptcy, death, disability, retirement or relocation. In addition, the governing document should consider the circumstances under which the entire entity can be unwound, whether by vote of the owners or following certain time, financial or regulatory triggers.

Of recent moment, the Whole Hospital Exception has been and remains under serious attack. The House of Representative's version of the SCHIP reauthorization bill, which was passed by the House, would have effectively eliminated the Whole Hospital Exception.30 Although the Whole Hospital Exception amendment was eventually removed from the compromise bill passed by both houses that President Bush ultimately vetoed,31 its future is uncertain. Consequently, every governing document for a Syndication should include a clear unwind provision so that ownership can be orderly trans- ferred following certain pre-determined regulatory events, such as the passage of a material amendment to or elimination of the Whole Hospital Exception.

Anticipate the Big Issues

It is good practice to anticipate issues that may arise during a Syndication that necessarily will be the most important to physician-investors, and to develop a plan to address them. Consider the following recurring issues:

• the inclusion of a noncompete clause;

• the scope of the noncompete clause and grandfathering of prior relationships;

• the possible requirement for physicians to sign pro rata guarantees on hospital debt;

• the potential guarantee of tax distributions;

• the possibility of upper limits on purchases by any single physician;

• the circumstances under which ownership can be transferred, if any; and

• the circumstances under which physicians will be required to sell their ownership back to the hospital, if any.

By addressing hot-button issues early in the process and clearly documenting how those issues will be handled, problems can be identified and resolved before they grow into crises, expectations can be managed, and physician-investor disaffection can be minimized.

Conducting a Syndication

A Syndication is simply a private securities offering of ownership interests in a hospital (or its parent). As a securities offering, federal and state securities laws determine the manner in which the offering and sale of ownership interests must be conducted. Because the interests themselves represent ownership in a hospital, fraud and abuse laws of course apply to the offering and must also be considered. Below are some guidelines for conducting a successful Syndication.

Don't Stray Too Far from the Path

There are no federal AKS safe harbors that specifically apply to physician ownership in hospitals. Moreover, most hospitals likely would not be able to satisfy all elements of the safe harbors generally applicable to investment interests. Nevertheless, it is good practice to structure a Syndication to comply with as many elements of the most applicable safe harbor. Most Syndications will follow the so-called "Small Entity Investment Interest Safe Harbor."32 It is also prudent to conform any planned Syndication as closely as possible to other Office of Inspector General ("OIG") guidance applicable to physician- hospital joint ventures, such as Fraud Alerts, Special Advisory Bulletins and Advisory Opinions.

(a) Small Entity Investment Interest Safe Harbor

The Small Entity Investment Interest Safe Harbor applies to investments in healthcare entities by potential referral sources, including physicians, where ownership by potential referral sources is limited and certain other requirements are met. To qualify for protection under this safe harbor, the following eight requirements must be satisfied:

• No more than 40% of the total investment interests of each class of investments is held by investors who are in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity.

• The terms on which an investment interest is offered to a passive investor who is in a position to make or influence referrals to, furnish items or services to, or otherwise generate business for the entity are no different from the terms offered to passive investors not in such a position.

• The terms on which an investment interest is offered to an investor is not related to the previous or expected volume of referrals, items or services furnished, or business generated from that investor to the entity.

• There is no requirement that the investors make referrals to, furnish items or services to, be in a position to make or influence referrals to, or otherwise generate business for the entity as a condition for remaining as an investor.

• The entity does not market or furnish the entity's items or services to passive investors differently than to non-investors.

• No more than 40% of the gross revenues of the entity in any fiscal year or previous 12-month period come from referrals from, items or services furnished by, or business otherwise generated by investors.

• The funds used to purchase the investment interest of each investor who is in a position to make or influence referrals to, furnish items or services to, or generate business were not loaned or guaranteed by the entity.

• The amount of return is directly proportional to the amount of the capital investment (including the fair market value of any preoperational services rendered) of that investor.33

Although the 40% tests may be difficult or impossible to satisfy, a properly structured Syndication should be able to satisfy the remaining six components of the Small Entity Investment Interest Safe Harbor.

(b) Joint Venture Guidance

The OIG published a Special Advisory Bulletin in April 2003 and a Special Fraud Alert in 1989 in which the OIG outlined elements of joint ventures between referral sources that heighten risk of noncompliance under the AKS. In its 2003 Special Advisory Bulletin,34 the OIG listed indicia of "suspect" joint ventures, as follows:

• the referral-source investors bear little or no bona fide business risk;

• the manager is a would-be competitor with physician investors;

• the manager provides a broad scope of services, or "turn-key" operation;

• the practical effect of the arrangement is to allow the owners to profit from reimbursement that would otherwise be billed and paid to the manager; and

• the joint venture agreements contain noncompete clauses and other exclusivity provisions.

In the 1989 Special Fraud Alert35, the OIG provided other examples of "suspect" joint venture indicators:

• investors are chosen because they are in a position to make referrals;

• physicians expected to make a large number of referrals are offered a greater investment interest;

• physician investors are actively encouraged to make referrals;

• referrals by investors are tracked and this information is distributed to investors;

• physicians are required to divest their investment interests if they cease to practice in the service area;

• nominal or disproportionately low capital is required for investment when compared to returns and investments in a typical new business enterprise; and

• loans are advanced by joint venture to physician for purchase of investment interest.

At the risk of stating the obvious, the fewer elements of "suspect" joint ventures present in a proposed Syndication, the better. By incorporating the following elements in a Syndication, risk of noncompliance under the AKS can be minimized:

• physician investors are required to make a substantial investment at risk in the hospital;

• the terms of the investment will not take into account the volume of any physician investor's past or anticipated future referrals;

• no affiliate of the hospital will lend any funds or guarantee any debt on behalf of a physician investor;

• distributions will be allocated uniformly among all investors in proportion to their investment36 and will bear no relationship to patient referrals; and

• the investment interests are uniformly offered to all prospective investors on the same terms.

In addition to federal rules and guidance, the fraud and abuse laws of the state in which the Syndication will be conducted should be examined to determine whether it will comply with applicable laws. State law analogs to the AKS and the Stark Law vary dramatically and may range from professional licensing rules to criminal statutes.

Prepare an Offering Memorandum

Sales of securities in a Syndication (e.g., stock, partnership interests, and limited liability company interest) are governed by the Securities Act of 1933, as amended (the "Securities Act").37 The Securities Act generally requires registration of all sales of securities unless an exemption from registration is available.38 Structured properly, a Syndication should typically qualify for the so-called "private offering" exemption contained in Section 4(2) of the Securities Act.39 Regulation D promulgated under the Securities Act sets forth certain safe harbors that can be met in order to ensure that a particular securities offering is deemed a "private offering" under Section 4(2).40

The securities laws are designed to require that issuers provide investors with full, fair and complete disclosure about their business. Rule 502(b) specifically sets forth the disclosure requirements of Regulation D offerings and distinguishes between those offerings made to accredited investors41 and those made to non-accredited investors.42 When an offering is made only to accredited investors, "no specific form of disclosure is mandated," however, disclosures

of material information must still be made in order to comply with antifraud provisions of the securities laws.43 In contrast, when an offering is made to non-accredited investors, the level of disclosure is heightened, pursuant to Rule 502(b)(2).

It is commonplace for Syndications to include some form of disclosure document, whether an offering memorandum (also called a "private placement memorandum" or "prospectus"), purchase agreement or similar instrument. The primary purpose of such a document is to fulfill the disclosure requirements of Rule 502(b)(2), while serving as a shield against any future charges of violating antifraud provisions of the securities laws. Such a document will also serve as an outline of the transaction and a tool for marketing the offering. An offering memorandum is generally the most effective means of disclosure in "retail" offerings, which are offerings in which the price and terms are set in advance. By contrast, in a negotiated Syndication, it is permissible to use purchase agreements and other alternative disclosure documents. However, using an offering memorandum when marketing to physicians who are not represented by counsel and are not particularly experienced with private equity transactions would generally present a lower risk under the securities laws.

Take Care With Pre-Offering Communications

A common question is what pre-offering communications can be conducted with potential physician investors, and more particularly, how can the hospital publicize the offering to drive physician participation. As a threshold matter, Rule 502(c) of Regulation D prohibits issuers from engaging in any form of general advertising or general solicitation in connection with the offer or sale of securities in an exempt private offering. This rule lists activities that are specifically prohibited, but makes clear that these are not the only types of activities that may constitute a prohibited solicitation. For example, Rule 502(c)(1)(2) specifically prohibits "[a]ny advertisement, article, notice or other communication published in any news - paper, magazine, or similar media or broadcast over television or radio; and [a]ny seminar or meeting whose attendees have been invited by any general solicitation or general advertising."

Although it is not entirely clear what constitutes general solicitation or advertisement in a private offering, the SEC staff has issued a number of noaction letters to provide guidance on the manner in which private offerings can be conducted. For example:

• The existence of a preexisting relationship between the issuer and the offeree is strong evidence of the absence of a general solicitation.44

• Records that document the number of offerees and their qualifications or relationship with the issuer can be helpful in demonstrating the absence of a general solicitation.45

• Contacting all of the professionals of a particular type in a given state, with a view toward soliciting interest in sales of securities covering a service related to their profession, may be considered to be a general solicitation.46

An effective tool for conducting a Syndication without running afoul of the prohibitions against general advertising or general solicitation is to be able to document the existence of a substantive and pre-existing relationship between the hospital and the prospective physician investor. In addition, measures such as tracking offerees, pre-qualification questionnaires, careful use of

registered broker-dealers, and other qualification techniques should be employed as the relationship of the offerees to the issuer becomes more tenuous and the number of offerees increases.

Review Operational Documentation

It is common practice for health systems and healthcare companies to establish a variety of arrangements between participant hospitals and one or more affiliates, including space leases, equipment leases, employee leases, management contracts, and shared services agreements. A Syndication provides an excellent opportunity to review affiliate documentation and ensure that all regulatory and internal policy requirements are being fulfilled. Because physician owners could be deemed to receive a “kickback” in the form of higher returns as a result of affiliate payments or the provision of any affiliate services, all such affiliate arrangements should be reviewed to determine whether they satisfy the various exceptions set forth in the AKS, including the exceptions relating to space rental,47 equipment rental,48 and personal services and management contracts.49 This will require generally that all such arrangements:

• be set out in writing signed by the parties;

• cover all services being provided under the arrangement (or in the case of personal services and management contracts, cover or cross-reference all services being provided);

• specify the intervals of any periodic services;

• have a term of not less than one year;

• set the aggregate compensation in

advance, in a manner consistent with fair market value, and not in a manner that takes into account the volume or value of referrals or business otherwise generated by the parties; and

• not exceed what is reasonably necessary to accomplish the commercially reasonable purpose of the arrangement.

In determining fair market value, a third-party independent valuation company should be used, if possible. If that is not possible or financially feasible, be sure to rely on a recognized procedure for determining fair market value, such as IRS Revenue Ruling 59- 6050 or Standard 9 of the Uniform Standards of Professional Appraisal Practice.51 In addition, ensure that all costs are being captured for any affiliate services provided, such as the fully loaded benefit costs for employees leased to the hospital, and the fully allocated overhead costs of providing managements services under a management agreement.

Conclusion

Legislative and regulatory efforts to curtail or eliminate physician ownership of hospitals are unlikely to abate. However, industry efforts to preserve physician ownership of hospitals are equally fervent. Although a Syndication can be a complex undertaking characterized by numerous competing business objectives and legal considerations, the benefits of these

transactions can be manifold if properly structured. An effectively planned and executed Syndication can result in mutual economic benefits for both the hospital and physician investors. More importantly, active physician investment in hospitals can lead to stronger physician hospital relations, greater physician involvement in hospital operations, and ultimately, better patient care.

Matthew Aiken is a Partner in Balch & Bingham's Birmingham office and serves as Chairman of the firm's Health Law Practice Group. He has substantial experience representing healthcare providers, health services companies and private equity funds that invest in the healthcare industry. Mr. Aiken received a B.A. from the University of Virginia in 1992 and a J.D. from Georgetown University Law Center in 1995, where he served as Editor-in-Chief of The Tax Lawyer. Prior to beginning private practice, he served as a Law Clerk to the Honorable Robert B. Propst, United States District Judge. In 2004, Mr. Aiken was named by the Birmingham Business Journal as a member of its "Top 40 Under 40." He is also listed in "The Best Lawyers in America." He may be reached at maiken@balch.com.

Daniel Murphy is an attorney in Balch & Bingham's Health Law and Corporate & Securities Practice Groups. His practice focuses on healthcare industry regulation and transactions. He has recently assisted and advised public and private health care companies, hospitals, ASCs, diagnostic imaging facilities, DME suppliers, physician practices and other clients.

Mr. Murphy received his juris doctorate University of Virginia School of Law, and bachelor of arts, magna cum laude, from the University of Notre Dame, where served as the President and Pipe Major of the Notre Dame Bagpipe Band. Prior to practicing law, Mr. Murphy worked in the corporate finance department of Baxter Healthcare Corporation in Vienna, Austria and Illinois. Mr. Murphy speaks and writes German. He can be reached at dmurphy@balch.com.

Endnotes

1 For purposes of this article, the authors consider a hospital to be any hospital that meets the statutory definition for the term contained in Section 1861 of the Social Security Act, 42 U.S.C. § 1395x(e) (2004), which includes general acute care hospitals, inpatient rehabilitation hospitals, specialty hospitals and others.

2 American Surgical Hospital Association Becomes Physician Hospitals of America, Health & Medicine Week 40, Dec. 4, 2006.

3 Children's Health and Medicare Protection Act of 2007, H.R. 3162, 110th Cong. (2007). The Whole Hospital Exception amendment was removed from the House of Representatives Bill to reauthorize SCHIP that ultimately passed both the Senate and the House of Representatives (H.R. 976). President Bush vetoed the bill on October 3, 2007 and Congress failed to override the veto.

4 See, e.g., Drew Armstrong, Specialty Hospitals Under the Knife, CQ Weekly (Feb. 24, 2007); see also, Jessica Zigmond, Special Effects: With Moratorium Over, Specialty Projects Growing – Slowly for Now, Modern Health Care, Oct. 30, 2006.

5 See Press Release, Ctr. For Medicare and Medicaid Services, CMS Outlines Next Steps as Moratorium on New Specialty Hospitals Expires (June 9, 2005), available at http://www.cms.hhs.gov/media/press/ release.asp?Counter=1478.

6 See, e.g., Del. Gen. Corp. Law 8 § 266; Ala. Code § 10-15-3.

7 See, e.g., In. Code § 23-1-38.5-10.

8 See 42 C.F.R. § 489.18; Medicare Program Integrity Manual, Chapter 10 § 5.5(C).

9 See Medicare Enrollment Application, Form 855-A. A change of information filing is essentially a perfunctory, ministerial filing to update information in a provider's or supplier's Medicare enrollment profile. A change of ownership application, on the other hand, entails review and approval by CMS that can result in reimbursement delays.

10 42 U.S.C. § 1395nn.

11 42 U.S.C. § 1395nn(h)(6)(K).

12 42 U.S.C. § 1395nn(d)(3).

13 The other available exception is the so-called "Rural Provider Exception." 42 U.S.C. § 1395nn(d)(2). The Rural Provider Exception exempts physician ownership in a hospital or other healthcare provider from Stark Law prohibitions if substantially all of the DHS furnished by the entity are furnished to individuals residing in a rural area. The term "rural area" is defined elsewhere in the Social Security Act as an area outside of a metropolitan statistical area, as defined by Office of Management and Budget. Therefore, if a hospital furnishes substantially all of the DHS it provides to residents located outside of a metropolitan statistical area, the Rural Provider Exception would apply. An exception also exists for physician ownership interests in hospitals located in Puerto Rico.

14 42 C.F.R. § 411.356(c)(3).

15 Medicare and Medicare Programs; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships, 63 Fed. Reg. 1659, 1679 (Jan. 9, 1998).

16 Id.

17 Usually, no physical site survey will be conducted prior to the effective date of a CHOW. However, after a CHOW has been processed by the fiscal intermediary or carrier, the state will typically conduct a survey of the divested health provider.

18 CON laws are state healthcare laws that were originally enacted to control healthcare costs by regulating and coordinating the supply of various types of healthcare providers. CON laws vary widely from state to state, but typically require prospective healthcare providers to obtain a CON or exemption from CON coverage in order to establish new healthcare facilities, offer new healthcare services, or to acquire new healthcare facilities or equipment, all as defined by statute and regulation. CON laws commonly charge state agencies with evaluating the community need

for a project (based on state-collected demographic data) according to statutory and regulatory criteria in making a determination on whether to issue a CON. As of January 2007, approximately 36 states had some form of CON regulation. See Certificate of Need: State Health Laws and Programs, National Conference of State Legislatures, available at http://www.ncsl.org/programs/health/certneed. htm.

19 See supra, note 10.

20 See, e.g., OIG, Special Advisory Bulletin, Contractual Joint Ventures at 6 (Apr. 23, 2003), available at http://www.oig.hhs.gov/fraud/docs/alertsandbulletins/042303SABJointVentures.pdf.

21 15 U.S.C. § 77a, et seq.

22 This provision must be included if the Syndication occurs in a state in which the physician self-referral law requires disclosure of investment interests to patients selfreferred by the investing physician.

23 See supra, note 14.

24 42 C.F.R. § 411.355-356.

25 42 C.F.R. § 411.354(b)(5),(c)(2).

26 See, 66 Fed. Reg. 868; 69 Fed. Reg. 16059.

27 72 Fed. Reg. 51,027-29 (Sept. 5, 2007).

28 Id. at 51,027.

29 Id. at 51,028.

30 See supra, note 3, at § 651.

31 Sheryl Gay Stolberg and Carl Hulse, Bush Vetoes Child Health Bill Privately, N.Y. Times,

Oct. 4, 2007.

32 42 C.F. R. § 1001.952(a)(2). The other generally applicable safe harbors are the Large Entity Investment Safe Harbor (42 C.F.R. § 1001.952(a)(1)) and the Medically Underserved Area Safe Harbor (42 C.F.R. § 1001.952(a)(3)).

33 42 C.F.R. § 1001.952(a)(2).

34 OIG, Special Advisory Bulletin, Contractual Joint Ventures (Apr. 2003), available at http://www.oig.hhs.gov/fraud/docs/alertsandbulletins/ 042303SABJointVentures.pdf.

35 OIG, Special Fraud Alert, Suspect Joint Ventures: What to Look For, 59 Fed. Reg. 31,157 (Dec. 19, 1994), available at http://www.oig.hhs.gov/fraud/docs/alertsandbulletins/ 121994.html.

36 See OIG Advisory Opinion No. 07-05 (June 19, 2007), available at http://www.oig.hhs.gov/fraud/docs/advisoryopinions/2007/AdvOpn07- 05C.pdf. Although OIG Advisory Opinion 07-05 specifically addressed physician-hospital joint ventures in ambulatory surgery centers, the interpretation of directly proportional returns on investment in that opinion could also apply to physician-hospital joint ventures in hospitals. In this opinion, the OIG affirmed its view that profit distributions and return on investment should be in proportion to the amount of capital invested. Because Syndication equity unit prices are set at fair market value at the time of sale, and profit distributions are based on percentage of ownership, the rationale in this advisory opinion could lead to the bizarre result of the OIG interpreting pro rata distributions based on fair market value purchases at different times as not "directly proportional."

37 15 U.S.C. § 77a, et seq.

38 Id.

39 15 U.S.C. at 77d(2).

40 17 C.F.R. § 230.501-508.

41 To qualify as an "accredited investor," a physician must either (a) have an individual net worth, or joint net worth with such person's spouse, that exceeds $1,000,000 or (b) have an individual income in excess of $200,000 in each of the two most recent years or joint income with such person's spouse in excess of $300,000 in each of those years and has a reasonable expectation of reaching the same income level in the current year. See Rule 501(a) of the Securities Act.

42 17 C.F.R. § 230.502(b).

43 Steven C. Alberty, 1 Advising Small Businesses, § 17:13 (2007).

44 See SEC Rel. No. 33-6339 [1981-1982 Transfer Binder] Fed. Sec. L. Rep. (CCH) ¶83,014 at n.30 (Aug. 7, 1981) ("[T]he commission cautions issuers, however, that depending on the actual circumstances, offerings made to such a large numbers of purchasers may involve a violation of the prohibitions against general solicitation and general advertising.").

45 See In re Kenman Corp., SEC Rel. No. 34- 21962 [1985-1986 Transfer Binder], Fed. Sec. L. Rep. (CCH) ¶83,767 (Apr. 19, 1985).

46 Mobile Biopsy, LLC, SEC No-Action Letter, [1999-2000 Transfer Binder] Fed. Sec. L. Rep. (CCH) ¶77,613, 1999 SEC No-Act. LEXIS 681 (Aug. 11, 1999) (denying a medical equipment LLC's proposed mailing to local doctors knowledgeable about their services and users because, although the offering was crafted to comply with Rule 506, the SEC found the mailing a prohibited "general solicitation" within Rule 502(c)).

47 42 C.F.R. § 1001.952(b).

48 42 C.F.R. § 1001.952(c).

49 42 C.F.R. § 1001.952(d).

50 Rev. Rul. 59-60, 1959-1 C.B. 237 (1959).

51 BUSINESS APPRAISAL, DEVELOPMENT, Uniform Standards of Professional Appraisal Practice No. 9 (2006).

Copyright 2008© by the American Bar Association. Reprinted with permission. This information or any or portion thereof may not be copied or disseminated in any form or by any means or stored in an electronic database or retrieval system without the express written consent of the American Bar Association.