"Work-Arounds" For Physician-Owned Hospitals: Are They Workable? Health Lawyers Weekly, American Health Lawyers Association, Vol. 8, Issue 24, Co-authored with Cheryl Camin

06.18.10

Winstead News Alert

Physician-owned hospitals in development and under construction face a healthcare reform law-imposed December 31, 2010 deadline for obtaining their state licenses and Medicare provider agreements. According to the Physician Hospitals of America, 27 physician-owned hospitals have halted construction and approximately 40 other physician-owned hospitals are either racing ahead with construction to beat the deadline or have transferred ownership to existing hospitals and other parties not affected by the ban on physician ownership.[1] The search for a "work-around" to the end of the Stark Whole Hospital Exception is being pursued by physicians, lenders, consultants, attorneys, and others to keep physician ownership as a viable strategy for physicians seeking investment returns and governance and management control of hospitals.[2]

Whole Hospital Exception Ends

The Stark Law generally prohibits a physician from making a referral of a Medicare patient for designated health services, including inpatient and outpatient hospital services, to an entity with which the physician (or an immediate family member) has a financial relationship, unless an exception applies.[3] Financial relationships include ownership or investment interests in the entity through debt, equity, or other means.[4] Consequently, physician ownership in hospitals has been banned unless there is a Stark Law exception, such as the "Whole Hospital Exception," which permits a physician's ownership or investment interest in the entire hospital as opposed to merely a distinct part or department of the hospital.[5]

The passage of healthcare reform eliminated the application of the Whole Hospital Exception to physician-owned hospitals, which do not have their Medicare provider agreements in place by December 31, 2010.[6] As a result, newly formed physician owned hospitals that do not have their Medicare provider agreements in place by December 31 will be prohibited, unless a "work-around" can be found.

The "Work-Arounds"

The possibility of viable "work-arounds" of the ban on physician-owned hospitals is limited by Stark itself. An ownership or investment interest in a hospital not only includes direct equity or debt relationships between a physician and a hospital, but also includes an interest by a physician in a company that holds an ownership or investment interest in a hospital. Similarly, physicians are prohibited from investing in a subsidiary company that holds an investment interest in a parent company (or other subsidiary companies) that owns a hospital.

PTS Exception

One possibility for continued physician ownerships of hospitals is through the publicly traded securities exception to Stark (PTS Exception). The PTS Exception permits physicians to own investment securities that may be purchased on the open market and are:

- Either (1) listed for trading on the NYSE, AMEX or any regional exchange in which daily quotations are published, or foreign securities listed on a recognized foreign, national, or regional exchange with published daily quotations, or (2) traded under an automated interdealer quotation system operated by NASDAQ; and
- In a corporation that has stockholder equity exceeding $75 million at the end of the corporation's most recent fiscal year or an average during the previous three fiscal years.[7]

The PTS Exception would be pursued through a roll-up initial public offering (Roll-up IPO). This would be a transaction in which a shell company goes public while simultaneously merging into the shell a number of the physician-owned hospitals. The Roll-up IPO provides the company with liquid shares and cash that the company uses to purchase the ownership interests of the physicians in the physician-owned hospitals that are consolidated. Each physician will then own shares in the company, and each hospital will become a subsidiary of the Roll-up IPO company.

Physician-owned hospitals that are under development or in construction will likely have many concerns in using the PTS Exception. First, the PTS Exception requires that the Roll-up Company has completed at least one fiscal year of existence.

Second, such hospitals have to be appraised and a value assigned to each physician ownership interest in each hospital that is consolidated in the Roll-up IPO. An exchange ratio is established for the exchange of interest in the Roll-up IPO company upon contribution of the physician ownership interests in each hospital. Given the preoperational status of these physician-owned hospitals, it is unlikely that they could achieve stockholder equity exceeding $75 million through the Roll-up IPO without involving grandfathered physician-owned hospitals.[8] However, grandfathered physician-owned hospitals may be interested in the Roll-up IPO as the health reform law limits their expansion, while a publicly traded company would not be subject to such limits.[9]

Third, the Roll-up IPO depends upon the consent of all of the physician owners of the hospitals and existing lenders to the portfolio of consolidated hospitals and possible consent of other third parties. Because the Roll-up IPO may be viewed as a change of ownership (CHOW) or control, participating grandfathered physician-owned hospitals would have to submit Medicare, Medicaid, and state licensing agency CHOW filings and may have to obtain consents on contracts, which contain restrictions on transfer and/or ownership of the hospital, e.g., managed care contracts. Considerable legal, accounting and valuation expenses would be involved to comply with securities and tax laws for a Roll-up IPO.

ESOP Conversion

A second “work-around” is the conversion, in whole or in part, of an existing hospital to an employee-owned hospital through an employee stock ownership plan (ESOP). Physicians could then become direct employees of the hospital and participate as employee-owners through the ESOP. The ESOP would be given certain governance and management roles in the hospital including positions on the hospital’s board of directors and in executive management capacities. However, direct physician employment by an ESOP-owned hospital is not permitted in states enforcing the prohibition against the corporate practice of medicine, such as Texas where much of the physician-owned hospital development is occurring.

The Stark Law permits hospitals to directly employ physicians if the arrangement complies with a *bona fide* employment relationship exception.[10] However, few hospitals desire to directly employ physicians in order to protect the hospital from liabilities of the physicians’ practices. Physicians are typically organized into a hospital subsidiary or “captive” medical practice in order to assure their autonomy for the practice of medicine. Hospitals also desire to have flexibility in compensating recruited physicians and other physicians (e.g., whose practices have been acquired) that the Stark employment exception does not permit.

For example, a hospital cannot form a group practice of its employed physicians without organizing them into an entity separate and distinct from the hospital entity.[11] Consequently, physicians are unable to both meet the Stark group practice definition (necessary for qualifying for the in-office ancillary services exception as well as more flexible compensation methods) and be directly employed by an ESOP-owned hospital.

Unsecured Loan

The third “work-around” involves the physicians loaning money to the hospital through an unsecured loan subordinated to a credit facility, which is considered a compensation arrangement under Stark.[12] The credit facility would be comprised of the hospital’s debt financings for land, construction, equipment, and/or working capital. For purposes of Stark, the Centers for Medicare and Medicaid Services (CMS) believes a loan is not an ownership interest if a physician (or immediate family member) has made an unsecured or nonconvertible loan to a hospital, or a loan with no other indicia of ownership. “Indicia of ownership” that may disqualify the loan as a compensation arrangement include the physician-creditor’s participation in revenue or profits, subordinated payment terms to all general creditors, low or no interest terms, or ownership of convertible debentures.[13]

Physicians are likely to view an unsecured loan subordinated to a credit facility as an unattractive financial instrument compared to direct equity in a hospital. In structuring such a loan (or the purchase of a hospital's promissory note), the hospital would likely include the following features to attract physician interest:

- **Mezzanine Debt Financing Terms**—Mezzanine financing generally refers to a tier in a company's capital structure between debt and equity. Mezzanine debt financing may be in the form of subordinated, unsecured debt with the debt subordinated only to the credit facility. The maturity of the mezzanine debt typically depends on the scheduled maturity of other debt in the company's credit facility. Mezzanine debt investors usually expect a 15% to 25% internal rate of return (IRR) compared to a 25% to 50% IRR for equity investors. Consequently, the cash pay interest rate is typically 12% to 18%. The remainder of the desired IRR is usually obtained through value-add provisions such as an equity conversion right (only available to physicians if the whole hospital exception is restored). Given the higher risk of mezzanine debt financing, it is not unusual for the debt instrument to include rights for the mezzanine lender to be on the company's board of directors (or be able to appoint a director), to receive all of the issuer company's information provided to board members, senior lenders, or to be granted certain management rights to be able to participate in the management of the issuer.[14]
- **Governance and Management**—Physicians who purchase the mezzanine debt note will likely be given voting rights in the governance of the hospital through provisions in the hospital's organizational documents. Physicians also may be offered the opportunity to participate as owners of a management company venture to provide management services to the hospital. Physicians may have opportunities to be service providers to the management company and/or directly to the hospital through professional services, medical director, and on-call agreements.
- **Non-Competition and Transfer Limitations**—The non-competition and transfer limitations of the physicians' former equity investments will likely find their way into similar restrictions in the mezzanine company and the hospital's organizational documents.

The Stark issues for this unsecured loan strategy are complex and numerous. Since an unsecured loan subordinated to a credit facility is a compensation arrangement, as appropriate, a Stark compensation arrangement exception must be met. The "Isolated Transactions Exception," for one-time transactions, is not applicable as the note will involve installment payments that involve a mechanism to ensure payment even in the event of default by the purchaser or obligated party. It appears the only viable compensation exception is the Fair Market Value Compensation Exception (FMV Exception).[15] The FMV Exception has three major criteria that are obstacles to its use for these circumstances:

- **Fair Market Value**—The compensation paid to the physicians for purchasing the mezzanine debt note must be set in advance, consistent with fair market value, and not determined in a manner that takes into account the volume or value of referrals or other business generated by the referring physicians. "Fair market value" means the value in arms-length transactions, consistent with general market value.[16] An "arms-length transaction" means negotiations between unrelated parties regardless of whether they make referrals.[17] Whether physicians who did not have to meet the "arm's length transaction" description for the Whole Hospital Exception will be able to meet that description will depend on the facts and circumstances of the deal.

  "General market value," in a compensation arrangement context, means the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement, who are not otherwise in a position to generate business for the other party at the time of the service agreement.[18] The physicians buying the notes are likely to be referral sources to the hospital. "Fair market price" means the price or component that has been included in bona fide service agreements with comparable terms at the time of the agreement, where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals.[19] It is unlikely that comparable transactions involving physicians and hospitals (or other providers) exist for comparison purposes.
- ***Commercial Reasonableness***—Unlike fair market value, no definition of commercial reasonableness exists in the Stark rules. "Commercial reasonableness" has been described by CMS (or its predecessor agency) for all exceptions that require commercial reasonableness to mean:

- "... an arrangement was a sensible, prudent business arrangement from the perspective of the particular parties involved, even in the absence of potential referrals."[20]
- "An arrangement ... in the absence of referrals [that] would make commercial sense if entered into by a reasonable entity of a similar type and size and a reasonable physician (or family member or group practice) of similar scope and specialty, even if there were no potential DHS referrals."[21]

CMS desires "an analysis of the underlying economics of the transaction without taking into account the potential for referrals between the parties" as a commercial reasonableness inquiry, i.e., a quantifiable value created.[22] One governmental expert in a qui tam case stated the compensation arrangement must be essential to the functioning of the hospital with sound business reasons for paying the compensation to the physician.[23] Consequently, fundamental to evaluating the unsecured, subordinated loan is commercial reasonableness documentation that includes and supports: (1) a sensible prudent business arrangement, (2) commercial sense if entered into by reasonable, comparable parties, and (3) contracting parties from the perspective of no inpatient or outpatient referrals between them.

- **No Violation of Anti-Kickback**—CMS contends that its authority is expressly limited to arrangements that pose no risk of Medicare program or patient abuse. The statutory "no risk" standard is not limited to no risk under the Stark Law, but also no risk under the Anti-Kickback Statute. An arrangement will be considered to be at "no risk" under the Anti-Kickback Statute if it: (1) qualifies for an Anti-Kickback safe harbor, (2) receives a favorable advisory opinion from the Department of Health and Human Services Office of Inspector General (OIG) that the arrangement does not constitute illegal remuneration or will not be subject to any sanctions, or (3) does not violate the Anti-Kickback Statute.[24]

No safe harbor applies to unsecured loans subordinated to a credit facility. OIG advisory opinions take a year or longer to obtain. As a result, for most arrangements, in order to avoid an Anti-Kickback violation, the only condition that may be met is the receipt of a "no risk" legal opinion from an attorney. Few health law attorneys (or their law firms) are likely to depart from the minimal assessment of Anti-Kickback risk, which is usually expressed as "low" or "remote" risk versus the "no risk" opinion.

Conclusion

The New Year's Eve deadline to obtain a Medicare provider agreement imposes a formidable obstacle for physician-owned hospitals in development or under construction. No less formidable are the Stark compliance issues for "work-arounds" to the deadline.

Published in *Health Lawyers Weekly*, June 18, 2010, by the American Health Lawyers Association

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[1] Beaulieu, Debra, "Reality of Physician-Ownership Ban Hitting Home for Hospitals", Fierce Healthcare, May 7, 2010, accessed June 3, 2010 available at http://www.fiercehealthcare.com.

[2] The Physician Hospitals of America convened a May, 2010 conference titled "Next Steps for Physician Owned Hospitals."

[3] 42 U.S.C. § 1395nn(a)(1); 42 C.F.R. § 411.353(a).

[4] Id. at § 1395nn(a)(2); Id at § 411.354(b).

[5] Id. at § 1395nn(d)(3); Id at § 411.356(c)(3).

[6] Patient Protection and Affordable Care Act (PPACA) Pub. L. No. 111-148, Subtitle A,

Section 6001(a)(1)(i)(1)(A). Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, Section 1106(1).
[7] 42 U.S.C. § 1395nn(c)(1); 42 C.F.R. § 411.356(a).
[8] “Grandfathered” physician-owned hospitals are those hospitals with Medicare provider agreements prior to the December 31, 2010 deadline.
[9] Grandfathered physician-owned hospitals may not expand the number of operating rooms, procedure rooms, or beds for which the hospital was licensed on March 23, 2010, the date of enactment of PPACA, pursuant to PPACA, Section 6001(a)(1)(i)(1)(B).
[10] 42 U.S.C. § 1395nn(e)(2); 42 C.F.R. § 411.357(c).
[11] 69 Fed. Reg. 16077 (Mar. 26, 2004), 42 C.F.R. § 411.352(a).
[12] 42 C.F.R. § 411.354(b)(3)(iii).
[13] 63 Fed. Reg. 1707, (Jan. 9, 1998).
[14] Robinson, Arethur, Fert, Igor and Brod, Mark, "Fundamentals of Mezzanine Finance", Practical Law, June, 2010, p. 61-62, 65, 67.
[15] 42 C.F.R. § 411.357(l).
[16] Id. at § 411.351.
[17] 69 Fed. Reg. 16099 (Mar. 26, 2004).
[18] 42 C.F.R. § 411.351.
[19] Id.
[20] 63 Fed. Reg. 1700 (Jan. 9, 1998).
[21] 69 Fed. Reg. 16093 (Mar. 26, 2004).
[22] Hahn, Allen and Collier, H. Guy, “Fair Market Value: Appraisal Practice in an Evolving Legal Framework,” J. of Health Care Compliance, May-June, 2010, p. 10-11.
[23] McCann, Mayer Hoffman, and McNamara, Kathy, “Fair Market Valuation of Medical Director or Program Director Services,” filed with Plaintiff United States Designation of Expert Witness, July 12, 2004, in United States ex. rel. Kaczmarczyk, v. SCCI Hospital Ventures, No. H-99-1031 (S.D. Tex).
[24] 69 Fed. Reg. 16108 (Mar. 26, 2004); 42 C.F.R. § 411.351.