PHYSICIAN OWNERSHIP OF HOSPITALS: IDENTIFYING AND DEALING WITH THE RESTRICTIONS, OPTIONS AND RISKS FOLLOWING THE ENACTMENT OF PPACA AND RECENT LITIGATION

I. BACKGROUND

A. Scrutiny of Physician-Owned Specialty Hospitals

Critics of physician-owned specialty hospitals argue that because these facilities are physician-owned, they create incentives for physician owners to inappropriately "cherry pick" and refer their more profitable and healthier patients to their specialty hospitals, which, consequently, creates a financial problem for community hospitals. Critics also believe safety is an issue for specialty hospital patients because they are being treated in a facility that may be less prepared to handle postoperative emergencies. Over the years, critics' concerns regarding specialty hospitals have captured attention from Congress, CMS and the states.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 placed an 18-month moratorium, beginning on December 8, 2003, on physician-investor referrals of Medicare or Medicaid patients to specialty hospitals -- including referrals that would be permissible under the "whole hospital" exception.[1] For purposes of enforcing the moratorium, the term "specialty hospital" generally did not include any hospital already in operation or "under development" as of November 18, 2003. The moratorium expired on June 8, 2005. However, on June 9, 2005, CMS effectively extended the moratorium by instituting a six month suspension in the processing of Medicare enrollment applications submitted by specialty hospitals.[2] Subsequently, CMS issued extensions to the suspension, which Congress continued under section 5006(c) of the Deficit Reduction Act of 2005 (the "DRA"). The DRA also required CMS to develop a "strategic and implementing" report to address physician investment in specialty hospitals. The extension set by the DRA allowed CMS to suspend specialty hospital enrollment until the earlier of the date that CMS submitted a final report on physician investment in specialty hospitals (as required under Section 5006(a) of the DRA) or August 8, 2006, unless CMS extended the deadline for an additional two months as authorized under section 5006(c)(2) of the DRA. CMS submitted its final report to Congress on August 8, 2006.[3] Among the findings in CMS's DRA Report to Congress were the conclusions that CMS did not have the authority to continue the suspension on the enrollment of new physician-owned specialty hospitals past August 8, 2006 and that further suspension was not warranted.[4] Accordingly, the suspension was lifted.

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[1] *See* Medicare Prescription Drug Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (2003).

[2] *See* Press Release, Ctr. for Medicare and Medicaid Services, CMS Outlines Next Steps as Moratorium on New Specialty Hospitals Expires (June 9, 2005).

[3] *See* CTR. FOR MEDICARE & MEDICAID SERVICES, DEP'T OF HEALTH & HUMAN SERVICES, CMS FINAL REPORT TO CONGRESS AND STRATEGIC AND IMPLEMENTING PLAN REQUIRED UNDER SECTION 5006 OF THE DEFICIT REDUCTION ACT OF 2005 (Aug. 8, 2006), *available at* http://www.cms.hhs.gov/PhysicianSelfReferral/.

[4] *See id*. at 79.

In its DRA Report to Congress, CMS also stated that addressing issues related to physician investment in specialty hospitals involved promoting transparency of that investment. Furthermore, CMS stated that they would adopt a disclosure requirement requiring hospitals to disclose to patients whether they are physician-owned, and if so, disclose the names of the physician owners.[5] Accordingly, pursuant to the FY 2008 Inpatient Prospective Payment System, or IPPS, Final Rule, CMS began requiring that physician-owned hospitals furnish written notices to all patients at the beginning of their hospital stay or outpatient visit (i.e., upon the provision of a package of information regarding scheduled preadmission testing and registration for a planned hospital admission for inpatient care or an outpatient service) that the hospital is physician-owned and that a list of the physician owners is available upon request.[6] CMS may terminate a hospital's Medicare provider agreement for failure to comply with the disclosure requirement.[7] CMS may also deny a physician-owned hospital's initial provider agreement if the hospital does not have procedures for providing this notice.

B. The Whole Hospital Exception Prior to Health Reform

Stark generally prohibits physicians from referring Medicare patients for designated health services to entities in which they, or their immediate family members, have a financial relationship. There are many exceptions to this general rule, including the "whole hospital exception."

Historically, the Stark "whole hospital exception" permitted a physician with an ownership interest in a hospital to make referrals to that hospital, as long as the referring physician is authorized to perform services at the hospital, and the physician's ownership or investment interest is in the entire hospital, and not merely in a distinct part or department of the hospital.[8] In order to rely on the whole hospital exception, the physician's ownership or investment interest must have been in the hospital itself, and not merely a subdivision or department of the hospital. Furthermore, the whole hospital exception does not distinguish between specialty hospitals and full-service hospitals.

Even prior to Health Reform and following the 2003 moratorium, physician-owned specialty hospitals and the "whole hospital exception" faced political scrutiny. In 2007, the whole hospital exception came under heavy legislative attack. In response to the then upcoming expiration of the State Children's Health Insurance Program ("SCHIP") on September 30, 2007, two SCHIP bills emerged in Congress. The Senate approved its SCHIP bill (HR 976) on August 2, 2007.[9] The House passed its own bill (H.R. 3162) on August 1, 2007. H.R. 3162 included Medicare reforms that were not present in HR 976. The reforms appeared in Section 651 of the H.R. 3162 and included the elimination of Stark's whole hospital exception; however, it "grandfathered" existing specialty hospitals that were in operation and had a Medicare

[5] *See id.* at vii-viii.
[6] *See* 42 C.F.R. § 489.20(u)).
[7] *See id.* 42 C.F.R. § 489.53.
[8] 42 C.F.R. § 411.356(c)(iii).
[9] The language originated in S. 1893; however, the Senate struck the language in an unrelated House-passed tax measure (H.R. 976) and replaced it with the language ultimately contained in H.R. 976.

provider agreement as of July 24, 2007 as long as the existing specialty hospitals met new standards within 18 months of enactment. A conference committee was formed to reconcile the two versions and the conference bill did not contain the elimination of the whole hospital section. President Bush ultimately vetoed the conference bill.

C. OIG Reports on Physician-Owned Specialty Hospitals: January, 2008

In March of 2006, the U.S. Senate Finance Committee requested that the OIG conduct an evaluation of patient care and safety in physician-owned specialty hospitals. The request was triggered by two deaths of specialty hospital patients, one which occurred at a physician-owned hospital in Portland, Oregon in July, 2005 and the other death that occurred in January of 2007 at a 14-bed physician-owned hospital in Abilene, Texas. In each of these occurrences, neither hospital had a physician on duty at the time the emergency occurred and both hospitals called 9-1-1. In response, the OIG's report focused on the ability of physician-owned specialty hospitals to manage medical emergencies.[10]

The OIG's study evaluated hospital emergency-management policies and staffing records at 109 physician-owned specialty hospitals and focused on four primary sources of data: (1) a review of physician and nurse staffing schedules for 8 sampled days, (2) a review of hospitals' staffing policies, (3) a review of hospitals' policies for managing medical emergencies, and (4) structured interviews with administrators at each hospital. Overall, the OIG found patient care at some of the 109 physician-owned specialty hospitals surveyed to be compromised in some cases because:

- 55% of the 109 physician-owned hospitals reviewed had emergency "departments" and the majority of those had only one bed;

- Fewer than 1/3 of the hospitals had physicians on site at all times, and 34% relied on dialing 9-1-1 to get emergency medical assistance for patients in trouble;

- 7% of the hospitals failed to meet Medicare requirements that a registered nurse be on duty at all times and that at least one physician be on call if none are in the hospital; and

- 22% failed to have written policies addressing how emergency cases should be treated and evaluated when they arise.[11]

The report made the following recommendations to the Centers for Medicare and Medicaid Services ("CMS"), and CMS has concurred with these recommendations:

- Develop a system to identify and regularly track physician-owned specialty hospitals;

[10] *See id.*
[11] *See id.*

- Ensure that hospitals meet the current Medicare Conditions of Participation, or CoPs, that require a registered nurse to be on duty 24 hours a day, 7 days a week and a physician to be on call if one is not onsite;

- Ensure that hospitals have the capabilities to provide for the appraisal and initial treatment of emergencies and that they are not relying on 9-1-1 as a substitute for their own ability to provide these services; and

- Require hospitals to include necessary information in their written policies for managing a medical emergency, such as the use of emergency response equipment and the life-saving protocols to be followed.[12]

II. THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Patient Protection and Affordable Care Act[13] signed by President Obama on March 23, 2010 as amended by the Health Care and Education Reconciliation Act of 2010[14] enacted on March 30, 2010 (collectively referred to herein as the "ACA") amended the Stark Law's exception for physician ownership in a whole hospital as well as the rural provider exception (if the rural provider is a hospital) to eliminate the application of this exception for hospitals without a Medicare provider agreement prior to December 31, 2010 and, in addition, to significantly curtail the expansion of physician ownership in hospitals.[15] In addition to the time deadlines set forth in the ACA and summarized below, a hospital must comply with all of the requirements of this section of the ACA by September 23, 2011.

In a nutshell, the ACA amendment to the Stark Law adds a new subsection which imposes specific requirements on hospitals relying on the whole hospital exception. In order to meet the exception; a hospital must:

- have physician owners or investors[16] and a Medicare provider agreement in effect on December 31, 2010 (as noted below, CMS has interpreted the ACA to require physician ownership or investment as of March 23, 2010 pursuant to the bona fide investment provisions in the ACA);

- not expand facility capacity beyond the number of operating rooms, procedure rooms[17], and beds for which the hospital was licensed as of March 23, 2010, unless an

[12] *See id.*
[13] Pub. L. No. 111-148.
[14] Pub. L. No. 111-152.
[15] Pub. L. No. 111-148, § 6001.
[16] It should be noted that any physician or physician's immediate family member is considered to be a "physician owner or investor" under this provision of the ACA if he or she has a direct or indirect ownership or investment interest in the hospital.
[17] For purposes of understanding the expansion prohibition, a procedure room as defined as including rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed but excluding emergency rooms or departments.

exception is granted by the Secretary of the Department of Health and Human Services (the "Secretary");

- provide an annual report to HHS on the identity of each physician owner or investor and any other owners or investors in the hospital including the nature and extent of those ownership and investment interests;
- require that referring physician owners and investors disclose to patients the physician's ownership or investment interest in the hospital in time for the patient to make a meaningful decision on the receipt of care by the hospital;
- require the referring physician owner or investor to additionally disclose the treating physician's ownership or investment interest in the hospital, if one, in time for the patient to make a meaningful decision about the receipt of care at the hospital;
- not condition any physician ownership or investment interests directly or indirectly on a physician making or influencing referrals to or generating business for the hospital;
- comply with certain requirements designed to ensure that all ownership and investment interests in the hospital are *bona fide* (as described further below);
- inform patients before admission if the hospital does not have a physician available on the premises during all hours and receive a signed acknowledgement from the patient that they understand this fact;
- have the capacity to provide assessment and initial treatment of patients and refer and transfer patients to hospitals with the capability to treat the needs of patients involved;
- disclose on public websites or in any advertising by or on behalf of the hospital that fact that the hospital is partially owned or invested in by physicians; and
- not have been converted from an ASC on or after March 23, 2010.

CMS was directed to establish enforcement procedures for this section of the ACA. Enforcement may include unannounced site reviews of hospitals. In addition, beginning no later than May 1, 2012, CMS is required to conduct audits to determine if hospitals violate these requirements.

As mentioned above, the ACA specifically requires that a physician's investment or ownership in a hospital be *bona fide*. In order to be considered to be a *bona fide* investment, the following requirements must be met:

- The percentage of total value of the ownership or investment interests held in the hospital, or in an entity whose assets include the hospital, by physician owners or investors in the aggregate does not exceed such percentage as of March 23, 2010.

- Any ownership or investment interests that the hospital offers to a physician owner or investor are not offered on more favorable terms than the terms offered to a person who is not a physician owner or investor.

- The hospital (or any owner or investor in the hospital) does not directly or indirectly provide loans or financing for any investment in the hospital by a physician owner or investor.

- The hospital (or any owner or investor in the hospital) does not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any individual physician owner or investor or group of physician owners or investors that is related to acquiring any ownership or investment interest in the hospital.

- Ownership or investment returns are distributed to each owner or investor in the hospital in an amount that is directly proportional to the ownership or investment interest of such owner or investor in the hospital.

- Physician owners and investors do not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other owners or investors in the hospital or located near the premises of the hospital.

- The hospital does not offer a physician owner or investor the opportunity to purchase or lease any property under the control of the hospital or any other owner or investor in the hospital on more favorable terms than the terms offered to an individual who is not a physician owner or investor.

The ACA requires the Secretary to establish and implement an exception process to the prohibition on expansion by a hospital with physician owners or investors. In order to be eligible to apply for an exception, the hospital must (a) be located in a county in which the percentage increase in the population during the most recent 5 year period is at least 150 percent of the percentage increase in the population growth of the state in which the hospital is located during that period, as estimated by the Census Bureau; (b) have its annual percentage of total inpatient admissions that represent inpatient admissions under the Medicaid program be equal to or greater than the average percent of such admissions located in the county in the hospital is located; (c) not discriminate against beneficiaries of federal health care programs and not permit physicians practicing at the hospital to discriminate; (d) be located in a state in which the average bed capacity in the state is less than the national average bed capacity; and (e) have an average bed occupancy rate that is greater than the average bed occupancy rate in the state in which the hospital is located. Alternatively, a hospital may be eligible to apply for an exception if it is a "high Medicaid Facility." A "high Medicaid Facility" is defined as a hospital that: (x) is not the sole hospital in a county; (y) with respect to each of the 3 most recent years for which data is available, has an annual percent of total inpatient admissions that represent admissions under Medicaid that is estimated to be greater than such percent with respect to such admissions for any other hospital located in the county in which the hospital is located; and (z) does not

discriminate against beneficiaries of federal health care programs and not permit physicians practicing at the hospital to discriminate. For purposes of understanding the expansion prohibition, a procedure room is defined as including rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed but excluding emergency rooms or departments. CMS has not yet issued a proposed regulation regarding the expansion process but is required by the ACA to implement this process by January 1, 2012.

The ACA places the following restrictions on the expansion exception process for an applicable hospital: An applicable hospital may only apply for an exception up to once every 2 years. If an exception is granted, the applicable hospital may increase the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed above the baseline number of operating rooms, procedure rooms and beds[18] of the applicable hospital (or if the hospital has been granted a prior exception, above the number of operating rooms, procedure rooms and beds for which the hospital is licensed after the application of the most recent exception). An increase is not permitted if it would result in the number of operating rooms, procedure rooms and beds for which the applicable hospital is licensed exceeding 200% of the baseline number of operating rooms, procedure rooms, or beds of the applicable hospital. In addition, any increase for which an applicable hospital is licensed may only occur in facilities on the main campus of the applicable hospital. CMS's review of an application for an exception must be completed and the decision published in the Federal Register within 60 days of receipt of the completed application. The ACA explicitly prohibits any administrative or judicial review of the exception determination.

III. CMS OUTPATIENT PPS FINAL RULE

On November 24, 2010, CMS published the Outpatient Prospective Payment System ("OPPS") final rule for calendar year 2011.[19] This rule contains regulations implementing the changes to the whole hospital exception to the Stark Law. Specifically, the rule adds a new section § 411.362 to the Stark Law regulations contained in Title 42 of the Code of Federal Regulations.[20] This section is entitled "Additional requirements concerning physician ownership and investment in hospitals" and implements the ACA requirements discussed above. CMS did not address the exception process for facility expansion in this rule and instead plans on publishing a rule on the exception process at a later date. In general, the rule tracked the language and requirements in the ACA and attempted to read and interpret all of the above summarized provisions together. CMS notes that it will issue separate rule making to address the expansion exception process and annual reporting to HHS by hospitals. In addition, CMS declined to issue any specific regulations regarding enforcement at this time.

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[18] Baseline number of operating rooms, procedure rooms, and beds means the number of operating rooms, procedure rooms and beds for which the hospital was licensed on March 23, 2010 or in the case of a hospital which did not have a provider agreement on March 23rd, the effective date of such provider agreement (which must have an effective date prior to December 31, 2010).

[19] 75 Fed. Reg 71800 (November 24, 2010). Note that the preamble and comments regarding the ACA amendments to the whole hospital exception begin on page 72240 and the final regulations begin on page 72260.

[20] *Id.* Page 72260.

One helpful clarification in the rule is that a hospital may receive its provider agreement after December 31, 2010 provided that it has an effective on or before December 31, 2010.[21] However, controversy surrounds CMS's interpretation of two provisions. Section 6001(a)(3), which amends section 1877 of the Social Security Act to add a new section (i)(1)(A) of the Social Security Act, requires a hospital to have physician ownership or investment and a provider agreement in effect on December 31, 2010 but the addition of section (i)(1)(D) to section 1877 of the Social Security Act requires the percentage of the total value of the ownership or investment interest held in the hospital by the physician owners or investors to not exceed the percentage as of March 23, 2010. CMS has attempted to read these provisions together to require that, in order to meet the whole hospital exception to the Stark Law, the hospital must have had physician ownership as of March 23, 2010.[22] Pursuant to CMS's interpretation, a hospital cannot meet the exception, even if it has a provider agreement in effect as of December 31, 2010, if it had no physician ownership as of March 23, 2010 but obtained physician ownership after such date but prior to December 31, 2010. CMS received many comments on this interpretation but did not change its finding. It is important to note that CMS recognized in the preamble and comments to the rule that the bona fide investment level (percentage of physician ownership not number of physicians) may fluctuate as long as it never exceeds the level of physician ownership that existed on March 23, 2010.[23]

Several comments were also received regarding the reading of the ACA provision that all of the whole hospital exception requirements must be met by September 23, 2011 (i.e., 18 months after the bill was enacted). CMS states in the preamble and comment section to the rule that it interprets this provision as requiring compliance with all of the requirements by September 23, 2011 but notes that failure to satisfy earlier deadlines will preclude the use of the exception.[24]

Another issue clarified in the preamble and comments to the rule involves the prohibition on expansion of facility capacity beyond the number of operating rooms, procedure rooms and beds for which the hospital was licensed as of March 23, 2010 or, if the hospital was not licensed on that date, as of the effective date of the hospital's provider agreement (provided the provider agreement is in effect on December 31, 2010). CMS acknowledges that many states only license the beds in the hospital and not the operating or procedures rooms but adds that expansion is prohibited absent an exception granted by CMS regardless of whether the state licenses procedure or operating rooms.[25]

CMS further confirmed in the comments that expansion of the total number of operating rooms, procedure rooms and beds is restricted but that a hospital may replace beds and rooms with new beds or rooms so long as the total number of each does not increase.[26] However, if a hospital was in the process of expanding its beds, operating rooms or procedure rooms as of

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[21] *Id*. Page 72243.
[22] *Id*. Page 72242.
[23] *Id.*
[24] *Id.* Page 72244.
[25] *Id*. Page 72243.
[26] *Id.* Page 72244.

March 23, 2010 but did not have the rooms in existence on March 23rd, these rooms would not be included in the facility's baseline capacity. The hospital could apply for an exception to cover such expansion. It should be noted that an exception granted by CMS for a hospital's expansion only protects referrals made by physician owners and investors after the date the exception is granted. As mentioned above, CMS will issue a later rule detailing the exception application process.

IV. APPLICATION OF ACA AND REGULATIONS TO FACT PATTERNS

In light of the statutory and regulatory pronouncements, consider the following scenarios and discussion:

A. Creative joint venture arrangements among physicians and hospitals.

While physicians may not increase their ownership percentage in hospitals they own, there is no prohibition on physicians changing their ownership in such facilities.

> *Comment: Some commenters stated that CMS should clarify whether section 1877(i)(1)(D) of the Act would be violated if the total value of ownership or investment interests held in the hospital by physicians in the aggregate (the "bona fide investment level'') fluctuates. For example, one commenter inquired whether a hospital could repurchase the ownership interest held by a recently deceased physician (thereby reducing the bona fide investment level) and later resell that ownership interest to another physician, returning the bona fide investment limit to the same level it was on March 23, 2010.*
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> *Response: The bona fide investment level may fluctuate as long as it never exceeds the level that existed on March 23, 2010.*
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> *Comment: Many commenters stated that CMS should clarify whether a hospital can reduce or increase the number of physician owners as long as the percentage of the total value of physician ownership remains unchanged. The commenters believed that nothing in the statute precludes the addition of new physician owners as long as the percentage of ownership remains constant.*
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> *Response: We agree that section 1877(i)(1)(D) of the Act does not restrict the number of physicians that may have an ownership interest in a hospital. The bona fide investment level requirement would not be violated as long as the percentage of the total value of the ownership or investment interest held in the hospital by physician owners in the aggregate does not exceed such percentage as of March 23, 2010.*[27]

Assume for purposes of discussion that there are three hospitals located within a mid-sized geographic area. As of March 23, 2010, Hospital A is owned 50% by referring physicians

[27] *Id.* Page 72249.

and 50% by a for-profit hospital owner and management company (privately held) ("Management Company"); Hospital B is owned 100% by physicians (but not the same physicians that own Hospital A); and Hospital C is owned 100% by a not-for-profit hospital system.

Consider the following joint venture model and other arrangements among the parties. Management Company agrees to purchase 50% of equity in Hospital B directly from physician owners at fair market value determined by independent appraisal. Hospital A is also to be valued by an independent appraisal. Following closing of the sales transaction, Physicians from Hospital A and Hospital B contribute their equity in each entity directly to Newco. Thus, Newco only owns 50% of Hospital A and Hospital B, and the physicians own indirectly their interest. The ownership as of March 23, 2010 is preserved and not increased.

The equity of Newco that will be issued to the physicians from Hospital A and Hospital B is based upon relative value of the contributions. Newco would be able to syndicate interests to new physicians that are not presently in the ownership structure. Newco would also have the option to increase its ownership in Hospital B since the pre-March 23 ownership was 100%.

What are the benefits and risks associated with this venture; what challenges exist?

- Willing participants able to reach agreement.
- Management company able to cash out physicians as proposed.
- Restrictions within joint venture agreement assuring continued compliance with Stark requirements that physician owners have privileges; further bolster with appropriate buy-sell; ROFR; etc., subject to Stark and AKS scrutiny.
- How to price future buy outs; multiple of earnings approach?

  Comment: One commenter representing a hospital system requested clarification concerning whether hospitals may continue to condition a physician's ownership interest on his or her continued practice of medicine and require the physician to divest his or her investment interest in the hospital if the physician retires or ceases to practice medicine in the community served by the hospital.

  Response: Section 1877(i)(1)(C)(iii) of the Act prohibits a hospital from conditioning any physician ownership or investment interest either directly or indirectly on the physician's ability to make or influence referrals to the hospital. Depending on the facts, the conditions described by the commenter could implicate this provision.[28]

[28] *Id.* Page 72250.

- How to price future equity sales? Get an independent appraisal!

Several valuation lessons may be learned from the recent case of *U.S. v. Tuomey d/b/a Tuomey Healthcare System, Inc.*, U.S. Dist. Court S. C., C.A. No. 3:05-CV-2858-MJP. This case involved the prosecution of a hospital system under both the Stark law and the False Claims Act. The Department of Justice ("DOJ") alleged that Tuomey entered into compensation arrangements with physicians in violation of these statutes by paying physicians under contracts that exceeded fair market value and which were not commercially reasonable. While this was only a District Court case and therefore not precedential (and is still subject to appeal), it is nonetheless instructive and informative of the DOJ's position on appraisals of fair market value.

In the *Tuomey* case, the DOJ argued that expert analyses are only as credible as the people who prepare them. Fair market value consultants must be able to defend their conclusions and a "commercial reasonableness" analysis must be thorough and complete. Valuators have varying capabilities and firms come and go, making all the more reason to insure that their reports appear defensible. The DOJ further argued that there should be no "backing into" a fair market value and commercial reasonableness analysis. It may be that the fair market valuation calculation methodology for the sales price is of more significance to the DOJ than the actual amount of money paid. The jury found that *Tuomey* violated the Stark law but not the False Claims Act.

While an independent fair market value opinion should serve as a significant safeguard in establishing compliance regarding sales prices, there are few standards for the valuation process or regulation of valuation firms. In *Tuomey* the DOJ asserted that someone must thoroughly evaluate the valuator's findings. This leads to the question of where this responsibility rests. With legal counsel? What involvement should counsel have?

- Hospital A and Hospital B will face substantial restrictions on their ability to expand! (See discussion on page 6).

- This restriction may even impact physician/hospital integration efforts as many acquisitions of physician practices bring cath labs, procedure rooms, etc., from the physician office under the hospital umbrella.

"Except as provided in paragraph (3), the number of operating rooms, procedure rooms, and beds for which the hospital is licensed at any time on or after the date of the enactment of this subsection is no greater than the number of operating rooms, procedure rooms, and beds for which the hospital is licensed as of such date."[29]

Section 1877(i)(3)(G) specifies that "the term 'procedure rooms' includes rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed, except such term shall not include emergency rooms or departments (exclusive of rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed).'' Under our proposed definition of procedure rooms at Sec. 411.362(a)(2), the term is limited to the types of rooms specified in the

[29] Pub. L. No. 111-148, § 6001(a)(3).

statute. Although the statute would permit us to define "procedure rooms" to include rooms where other services are performed, we did not propose to do so. We encouraged public comments on whether "procedure rooms" should include rooms where additional services, such as CT or PET scans, or other services, are performed.[30]

> *Comment: One commenter contended that section 1877(i)(1)(B) of the Act does not provide any basis for including restrictions on how a hospital uses its beds, as long as it does not increase the number of beds beyond the number that were licensed on March 23, 2010. Another commenter similarly inquired whether operating rooms, procedure rooms, and beds could change purposes (for example, through the conversion of a cardiac catheterization room into an endoscopy room), as long as the number of operating rooms, procedure rooms, and beds in the aggregate did not increase. However, another commenter asserted that, under the terms of the statute, a hospital cannot reduce its operating rooms to increase the number of its procedure rooms, and each individual category must remain capped at its March 23, 2010 level.*
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> *Response: We interpret section 1877(i)(1)(B) of the Act to impose restrictions only on the aggregate number of operating rooms, procedure rooms, and beds. Therefore, we will not impose any restrictions regarding the manner in which a physician-owned hospital uses its beds, operating rooms, or procedure rooms. In other words, if a hospital is authorized to operate 20 beds, 2 operating rooms, and 2 procedure rooms, the hospital may reduce or increase the number of beds, operating rooms, or procedure rooms as long as the resulting aggregate number of beds, operating rooms, and procedure rooms does not exceed 24 (assuming any applicable licensure requirements are satisfied).*[31]

Based upon the foregoing, Hospital A and B could convert beds into procedure rooms or vice versa. In addition, rooms that did not provide "catheterizations, angiographies, angiograms, and endoscopies" could be added. With the advent of new technology, this might be an area for growth.

- Transactional concerns – structured as a contribution of ownership interests to Newco, our facilities should avoid most limitations on assignments of contracts, etc., for those agreements at the facility level except for those that have strong anti-assignment language that would define changes in control as changes of ownership. Further, a transfer of corporate stock or LLC interests should not constitute a CHOW for Medicare purposes.[32]

Newco could not own any interest in Hospital C. However, consider that Hospital C would like to become involved. What are the options that might be pursued?

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[30] *Supra*, note 19, page 72243.
[31] *Id*. Page 72245.
[32] 42 C.F.R. § 489.18(a)(3).

B. Management of Clinical Service Lines

In situations in which physicians do not own an interest or physician involvement may not have been sought, perhaps the parties should analyze and consider a management arrangement between the hospital and the physicians. The growth in the management or co-management agreements for clinical service lines is a hot topic at this time. In those circumstances in which physician ownership was not achieved prior to March 23, 2010, another way to align physicians with hospitals is the clinical service line management or co-management arrangement. Most hospitals are familiar with medical director relationships. Medical director relationships are focused on hourly service and involve small numbers of physicians. A management or co-management arrangement typically involves a larger number of medical staff physicians in the delivery of services. Compensation is not simply based upon hours worked, but usually include some sort of base payment and an incentive payment methodology.

In looking at our hypothetical situation, Newco cannot acquire any ownership interests in Hospital C. Even without the prohibitions of the ACA, as a not-for-profit entity, there are many limitations in place that would make an ownership arrangement impractical.

However, consider a clinical service line arrangement between NewCo and Hospital C. Such an arrangement would be intended to allow Hospital C to acquire management and other services provided and fostered by physicians. The physicians have particular expertise, provide greater clinical oversight and awareness, supervision (as allowed and sometimes required) of non-physician personnel, and, in some cases, may have been providing some of these services in a less than organized manner. Further, the delivery of these services gives the physicians a sense of involvement and ownership in the operational and clinical outcomes. All of these reasons are intended to and should foster better patient care and quality outcomes.

What are the concerns in this model?

- Management Agreement must meet Stark and AKS requirements.
- State self referral prohibitions.
- Tax exempt issues.
- Provider based status guidelines.

Finally, what other creative options are available? Recently, an article was published in the ABA *Health Lawyer* entitled "Workarounds for Physician-Owned Hospitals: Are They Workable?" Vol. 23, No. 2, December 2010. (Authors Lew Lefko and Cheryl Camin).

In this article, there were three principal workarounds: (i) publicly traded securities; (ii) ESOP conversion; and (iii) unsecured loans. Without going too deep into the article, consider a few of those ideas folded into our the themes outlined therein.

The notion of Hospitals A, B, and C somehow merging and becoming a publicly traded entity is remote; the requirements appear to be difficult to meet; the cost of being public is likely to exceed $1 million per year.

However, assume that Newco is now a viable entity with cash flow and earnings attributable to its ownership interests in Hospitals A and B, and the management agreement with Hospital C. If either Hospital A, B, or C wants to develop a new facility such as a new medical office building or a stand alone hospital surgery suite (in this situation, it would be a replacement of existing operating rooms, rather than new rooms), perhaps Newco would be willing to finance the facility for the hospital with a long term lease arrangement. This may not provide the most attractive of financial returns as the lease payments would be at fair market value. However, physicians often seek real estate investment opportunities and this further strengthens their ties with the hospitals.