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MEMORANDUM REGARDING AMBULATORY SURGERY CENTER JOINT VENTURES

This memorandum summarizes the primary legal and regulatory considerations relevant to structuring an ambulatory surgery center (“ASC”) joint venture between hospital and physician investors. The issues addressed in this memorandum include:

- (a) Federal Anti-Kickback Statute requirements, which restrict physician and hospital investment in ASC’s and impose a number of operational standards for ASC joint ventures;
- (b) Federal Stark law requirements, which impose restrictions on physician referrals to entities with which they have a financial relationship;
- (c) Federal Tax-Exemption requirements, which are applicable to the extent a non-profit, tax-exempt hospital is a participant in the ASC joint venture;
- (d) Valuation considerations, which are applicable to the extent a party is contributing non-cash assets to the joint venture;
- (e) Federal securities law requirements, which are applicable to the offering of investment interests in the ASC joint venture; and
- (f) Federal antitrust law considerations, which are applicable to price fixing and joint contracting issues that may arise between the ASC joint venture and its hospital partner.

This memorandum is not an exhaustive analysis of every legal issue that could arise with the formation or operation of an ASC joint venture, and this memorandum specifically does not address applicable state law requirements, which may include CON and licensure considerations as well as state anti-self referral statutes. This memorandum, however, highlights the key legal issues that arise with every ASC joint venture formation and offers guidance for structuring the ASC joint venture to satisfy these legal requirements.

INITIAL CONSIDERATIONS—THE JOINT VENTURE ENTITY

The formation of an ASC joint venture requires the creation of a new legal entity that will own and operate the ASC. A limited liability company (“LLC”) permits its members to enjoy the limitations on personal liability applicable to the shareholders of a corporation while

avoiding taxation at the entity level. Thus, we typically recommend that a venture be structured as an LLC.¹

An LLC is formed by filing Articles of Organization with the applicable Secretary of State. The Articles of Organization is generally a very standard document that contains only the information required by applicable state law and is not typically negotiated between the parties. The owners of the joint venture (often referred to as “members”) will also adopt an Operating Agreement that will serve as the venture’s principle governing document and will set forth the members’ agreements with respect to the purposes and powers of the entity, equity ownership, governance, distributions, non-competition, divestiture and other key terms. Unlike the Articles of Organization, the Operating Agreement is usually heavily negotiated among the owners of the joint venture and their respective counsel and often takes considerable time to develop and finalize.

FEDERAL ANTI-KICKBACK STATUTE

Legal Overview

The Federal Anti-Kickback Statute prohibits the knowing and willful offer or payment of remuneration, directly or indirectly, to any person in return for referring (or to induce such person to refer) an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment will be made in whole or in part under a federal health program.² Criminal and civil penalties apply to violations of the Anti-Kickback Statute. The Anti-Kickback Statute carves out certain practices that will not subject providers to liability. There are also safe harbor regulations that protect certain specified arrangements from prosecution under the Anti-Kickback Statute. An arrangement must meet all of the elements of a safe harbor to be protected from prosecution, although failure to comply with a safe harbor does not mean that the statute has necessarily been violated.

In the past, the OIG has expressed approval of joint venture transactions only in limited circumstances where the facts indicate appropriate safeguards are present to prevent potential violations of the Anti-Kickback Statute. In advisory opinions in which the OIG analyzes joint venture transactions, the OIG consistently notes that health care joint ventures in which investors are also sources of referrals or suppliers of items or services to the joint venture raise questions under the Anti-Kickback Statute. The OIG’s central concern is that profit distributions to investors in a joint venture, who are also referral sources to the joint venture, may potentially represent disguised remuneration for referrals and lead to overutilization, increased costs for federal health care programs, corruption of professional judgment, and unfair competition.

ASC Safe Harbor—General Requirements. The first step in an Anti-Kickback analysis of a joint venture transaction is to determine whether a safe harbor applies to the transaction. There is a safe harbor that is specifically applicable to ASC joint ventures.³ The ASC safe harbor has the following general requirements that are applicable to all physician/hospital joint ventures or physician-owned joint ventures:

¹ However, there may be state law issues (tax, licensure, etc.) that require a different legal structure.

² 42 U.S.C. §1320a-7b(b).

³ 42 C.F.R. §1001.952(r).

- (a) Physician investors are in a position to refer patients directly to the ASC joint venture and perform procedures on such referred patients;
- (b) The terms on which an investment interest in the joint venture is offered to any investor must not be related to the previous or expected volume of referrals, services furnished, or the amount of business otherwise generated from that investor to the joint venture;
- (c) At least one-third of each physician investor's medical practice income from all sources for the previous fiscal year or previous 12-month period must be derived from the physician's performance of ASC procedures (this requirement shall be referred to in this memorandum as the "one-third income test");⁴
- (d) The joint venture or any investor (or person or entity acting on their behalf) must not loan funds to, or guarantee a loan for, any person or entity for the purpose of acquiring an investment interest in the joint venture;
- (e) The amount of payment to any investor in return for their investment interest must be directly proportional to the amount of capital investment of that investor;
- (f) All ancillary services provided by the joint venture to beneficiaries of federal health care programs must be directly and integrally related to primary procedures performed at the ASC, and none may be separately billed to Medicare or other federal health care programs; and
- (g) The joint venture and each investor must treat patients receiving medical benefits or assistance under any federally-funded health care program, including Medicare and Medicaid, in a nondiscriminatory manner.

ASC Safe Harbor—Multi-Specialty ASC's. In addition to the requirements set forth above, there is an additional requirement that is applicable *only* if the ASC joint venture will operate a multi-specialty ASC. This requirement provides at least one-third of the ASC procedures performed by each physician investor during the previous fiscal year or previous 12-month period must be performed at the ASC joint venture (this requirement shall be referred to in this memorandum as the "one-third procedures test").⁵

Unlike the one-third income test, a physician investor's compliance with the one-third procedures test can only be determined after the ASC joint venture has been in operation for at least twelve months.

⁴ The term "ASC procedures" means any procedures on the list of Medicare-covered procedures for ambulatory surgical centers. This list was revised effective July 1, 2003.

⁵ The one-third procedures test is intended to mitigate the risk of referrals among physicians or surgeons in different specialties to help ensure that a physician's investment in an ASC will truly represent an extension of his or her office practice.

ASC Safe Harbor—Hospital Investor Requirements. There are additional requirements that are applicable when a hospital is an owner of the ASC joint venture. These requirements are:

- (a) The joint venture may not use space, equipment, or personnel located in, or owned by, the hospital unless such space, equipment, or personnel is provided pursuant to an agreement that complies with an applicable safe harbor;
- (b) The hospital may not include on its cost report or any claim for payment from a federally-funded health care program any costs associated with the ASC (unless such costs are required to be included by a federal health care program); and
- (c) The hospital may not be in a position to make or influence referrals directly or indirectly to any investor or to the joint venture.

Government agencies charged with enforcement of the federal laws regulating fraud and abuse have noted in commentary to regulations and advisory opinions that hospitals may influence referrals of patients through discharge planning, post-discharge care, marketing activities, and relationships with hospital-employed physicians. The commentary to the ASC safe harbor indicates that whether this requirement is met will depend on the facts and circumstances of the particular arrangement. Although the application of this interpretation is not entirely clear, the risk of an adverse finding with respect to this requirement can be reduced by establishing policies and procedures to prevent improper influence over physicians who are employed by the hospital or who have other relationships that may permit the hospital to influence their referrals.⁶

ASC Safe Harbor—Policy Considerations. The ASC safe harbor is unique from the manner in which the OIG analyzes other joint ventures under the Anti-Kickback Statute because ASC joint ventures are protected only to the extent that physician investors are in a position to make referrals to the joint venture. While this may appear to be a departure from the manner in which the OIG analyzes other joint ventures, the OIG distinguishes ASC joint ventures primarily on the basis that these joint ventures represent an extension of a physician-investor's office practice because the referring physicians will personally perform procedures in the ASC. In support of this position, the OIG offers the following commentary:

Where physicians own an ASC in which they will personally perform a significant number of procedures, obvious and legitimate business and professional reasons exist for the ownership, including convenience, professional autonomy, accountability and quality control. Moreover, any risk of overutilization or unnecessary surgery is already present by reason of the opportunity for a surgeon to generate his professional fee; the additional financial return from the ASC is not likely to increase the risk of overutilization of

⁶ Examples of steps the hospital can take to mitigate risk include (i) refraining from any actions to require or encourage hospital-affiliated physicians (including physicians who are employees, independent contractors and medical staff members) to refer patients to the ASC; (ii) not tracking referrals to the ASC, if any, by hospital-affiliated physicians; (iii) paying compensation to hospital-affiliated physicians that does not take into account, directly or indirectly, any referrals that they may make to the ASC; and (iv) disclosing its ownership interest in the ASC to hospital-affiliated physicians.

procedures significantly.⁷

This “extension of practice” policy is important to understanding the purpose and intent of the ASC safe harbor and the types of physician investors that the OIG views as posing less of a risk of violation of the Anti-Kickback Statute.

Where a venture is structured in a manner that satisfies all of the requirements of the applicable ASC safe harbor, it is protected from Anti-Kickback Statute challenge. While failure of the venture to satisfy all of the requirements of the ASC safe harbor will not necessarily result in a violation of the Anti-Kickback Statute, the venture should be structured in a manner that will minimize Anti-Kickback Statute risk by meeting as closely as possible the safe harbor requirements and by emphasizing compliance with the underlying purpose and intent of the ASC safe harbor. The degree of Anti-Kickback Statute risk presented by an ASC joint venture will be determined by whether the venture can be structured to receive the protection of the ASC safe harbor and, if not, by how closely to the safe harbor the venture can be structured.

Structuring an ASC Joint Venture to Comply With the Anti-Kickback Statute

Who may invest? Physician investors that satisfy all requirements of the ASC safe harbor, and group practices⁸ that are composed exclusively of such physicians, are permitted investors in an ASC. This would generally include surgeons and proceduralists that derive at least one-third of their total medical practice income from ASC procedures. Physician investors or other third parties who are not employed by the joint venture or any investor, are not in a position to provide items or services to the joint venture or any of its investors, and are not in a position to make or influence referrals directly or indirectly to the joint venture or any of its investors are also permissible investors in an ASC.⁹ With respect to physician investors that do not satisfy all requirements of the ASC safe harbor, we offer the following guidelines on permitted physician investors in an ASC:

(a) *Surgeons/proceduralists who do not meet the one-third income test.* A physician that derives a portion of his/her total medical practice income from ASC procedures, but does not meet the one-third income test, will take the venture out of the ASC safe harbor but will not necessarily pose increased risk under the Anti-Kickback Statute if the physician is not in a position to refer patients to other ASC investors for ASC procedures. There is no absolute threshold below the one-third income test that would make an investor unacceptable, but the further below the one-third income test an

⁷ 64 Fed. Reg. 63517 (November 19, 1999).

⁸ The ASC safe harbor defines “group practice” to include the Stark law definition of group practice. This would be the entity through which the physicians provide substantially all of their physician services. Often, physicians will want to form a separate entity for the sole purpose of holding the investment interest in the ASC. As long as this entity is owned exclusively by physicians who meet the requirements of the ASC safe harbor, the OIG has indicated that this ownership structure does not pose an additional risk of violation of the Anti-Kickback Statute (but it does not meet the express requirements of the ASC safe harbor). See OIG Advisory Opinion 01-17 (October 17, 2001).

⁹ The determination of whether an investor is a potential referral source is a factual one. The OIG will accept a written stipulation that for the life of the investment the investor will not make referrals to, furnish items or services to, or otherwise generate business for, the entity or any of its investors, provided that, in fact, the investor’s actions comport with the written stipulation.

investor falls, the less likely it becomes that ASC procedures are actually an integral part or “extension” of the investor’s physician practice and the more questionable it becomes as to why the parties want to include this physician in the joint venture.

(b) *Anesthesiologists.* Anesthesiologists may be permitted investors in an ASC, although including anesthesiologists in the venture will take the ASC out of compliance with the ASC safe harbor.¹⁰ The ASC safe harbor does not apply if investors include persons in a position to provide services to the venture. Anesthesiologists performing services at the ASC may be so characterized, particularly if those services are provided pursuant to a contract or other arrangement with the venture (even if the anesthesiologists bill patients and do not receive compensation directly from the venture). It is often the case, however, that investment in the venture by anesthesiologists will be desired based on factors that do not raise Anti-Kickback Statute concerns (*e.g.*, to involve them in clinical decision-making). The risk of a successful Anti-Kickback Statute challenge will be substantially reduced to the extent that it is unlikely that anesthesiologists who are investors in the venture will refer significant numbers of patients to other physician investors for services anticipated to be performed at the ASC.

(c) *Referring Physicians.* Physicians who do not perform ASC procedures, but who are in a position to refer patients to other ASC investors for ASC procedures, are not permissible investors in an ASC joint venture. This may include, for example, primary care physicians or specialists who do not personally perform ASC procedures but are a source of referrals of ASC procedures.

(d) *Group Investors.* Frequently, physicians will desire to invest in the ASC through their group practice or an affiliated entity. Rarely, will all physician owners of the entity satisfy the one-third income test. In this instance, the Anti-Kickback risk must be evaluated by looking at each physician owner of the group who does not meet the one-third income test and determining whether that physician is in a position to generate referrals of ASC procedures. For example, an orthopedic group may contain a number of physicians that derive the majority of their practice income from ASC procedures and also a spine surgeon who does not meet the one-third income test because of the volume of inpatient surgical revenue. In this instance, the group may still be a permissible investor without significantly increasing the risk of non-compliance with the Anti-Kickback Statute if the physicians who do not meet the one-third income test can attest that they are not in a position to refer, and will not refer, patients to other physician investors for ASC procedures (or any such referrals will be insubstantial). In contrast, investment in an ASC by a multi-specialty group practice that includes both referring physicians and proceduralists would involve significant Anti-Kickback Statute risk.¹¹

¹⁰ In the commentary to the ASC safe harbor, the OIG expressly declined to protect an investment in an ASC by anesthesiologists, stating that “investments by other physicians, such as anesthesiologists..., are not protected by the safe harbor if the physician or provider is in a position to provide items or services to, refer patients directly or indirectly to, or generate business for, the ASC or any of its investors. However, this interpretation is limited to traditional anesthesiologists, not anesthesiologists who perform pain management procedures. Pain management physicians often perform a high volume of ASC procedures and may meet the requirements of the ASC safe harbor.

¹¹ See Advisory Opinion 03-5 (February 13, 2003) in which the OIG concluded that an investment in an ASC by a multi-specialty group practice could generate prohibited remuneration under the Anti-Kickback Statute.

Primary care or referring physicians who will not perform procedures at the ASC, but are in a position to refer patients to other physician investors for ASC procedures, should not be included as permitted investors in an ASC (either individually or through a group).

In the formation stages of an ASC joint venture, it is necessary to consider who the targeted physician investors will be and whether, with this targeted group of physician investors, the ASC will be able to be structured and to operate in compliance with the ASC safe harbor. Absolute compliance with all elements of the ASC safe harbor is desirable to minimize legal risk. As a practical matter, however, an ASC is rarely able to satisfy all elements of the ASC safe harbor. Accordingly, we recommend that the ASC be structured, and the Operating Agreement require, that the ASC operate as closely as possible with the purpose and intent of the ASC safe harbor and in a manner that does not create a legal risk of remuneration for referrals in violation of the Anti-Kickback Statute. However, the governing board of the ASC should be granted discretion under the Operating Agreement to admit physician investors who do not create a significant risk of non-compliance with the Anti-Kickback Statute. The governing board should act with advice of legal counsel in making such determinations.

Allocation of Shares. The ASC safe harbor requires that the terms on which an investment interest is offered to an investor must not be related to the previous or expected volume or value of referrals or business generated from that investor. This requirement prohibits the venture from differentiating between investors with respect to the number of shares offered, or the number of shares awarded, if the distinctions are referral based (or could even appear to be referral based). All physicians should be offered an opportunity to invest in the venture on the same terms, and the governing board of the venture should accept subscriptions and allocate shares in a manner that is applied uniformly among all investors and is not related to referrals. These principles should be applied even if the venture is not operating in full compliance with the ASC safe harbor in order to mitigate the Anti-Kickback Statute risk.

Monitoring Compliance with the Anti-Kickback Statute. The joint venture's Operating Agreement should include standards for eligible physician investors in the joint venture. These eligible investor standards should be modeled after the requirements set forth in the ASC safe harbor, but may, as set forth above, give the governing board of the ASC discretion to admit certain physician investors who do not meet the safe harbor requirements.

Prior to admission as a member of the joint venture, prospective physician investors should be required to certify, in writing, that the physician meets the requirements for an eligible investor as set forth in the Operating Agreement. This certification may be included in the Subscription Agreement that is completed by each physician investor in order to purchase an investment interest in the joint venture. The governing board of the joint venture should carefully review and consider these certifications and request additional information or documentation, as necessary, to establish the accuracy of the certifications *prior to* admitting a physician to the joint venture. Any prospective physician investor who cannot certify that he/she meets the eligible investor standards should be admitted to the joint venture only to the extent the governing board makes a determination, with the advice of counsel, that the physician investor does not pose a significant risk of non-compliance with the Anti-Kickback Statute. In addition, such physician investors should be requested to sign a certification upon admission to the joint

venture that they are not in a position to refer, and will not refer, patients to other physician investors for ASC procedures (or any such referrals will be insubstantial).

The joint venture should also require that the physician investors recertify compliance with the eligible investor standards at least annually. The Operating Agreement should set forth a specific date each year on which such recertifications will occur and include standards for responsiveness. The Operating Agreement should further provide that physician investors who fail to timely provide the required certification or who no longer meet the eligible investor standards are subject to being divested from the joint venture.

Divestiture of Physician Investors. The Operating Agreement will contain certain events that may trigger the repurchase of a physician's investment interest in the joint venture. These events often include a physician's:

- (a) Bankruptcy or insolvency;
- (b) Retirement from the active practice of medicine or relocation outside the ASC's service area;
- (c) Death or disability;
- (d) Loss of medical staff privileges at the ASC;
- (e) Failure to satisfy the eligible investor standards or to timely file a certification of compliance with the eligible investor standards;
- (f) Breach of the Operating Agreement;
- (g) Exclusion from the Medicare or Medicaid programs; and/or
- (h) Criminal indictment or conviction.

Upon the occurrence of a triggering event, the joint venture or the other members will have an option to purchase the investment interest of the physician at a price and on the terms set forth in the Operating Agreement.

For a multi-specialty ASC joint venture that is operating outside the ASC safe harbor, there is often a tension that develops in the application of the one-third income test and the one-third procedures test. For example, the governing board may be eager to admit the anesthesiologist or the physician who almost (but not quite) meets the one-third income test, thereby taking the ASC out of the safe harbor. After a year or two of operation, the governing board may be equally eager to divest the physicians who are not meeting the one-third procedures test and "supporting the center."¹² Once the governing board has made a decision to

¹² The joint venture's concerns underlying compliance with the one-third procedures test may be adequately addressed through a non-compete that prohibits physician members from owning an interest in a competing facility. If the physician investor does not own an interest in a competing facility it is likely that the physician will perform substantially all of his or her cases at the joint venture ASC, other than cases that must be performed at other hospitals or ASC's for other reasons (e.g. patient preference, clinical issues, managed care issues).

operate the ASC outside the safe harbor, the ability to use the one-third procedures test as a “sword” to eliminate non-referring physicians becomes much more difficult and increases legal and litigation risk. A conservative approach under the Anti-Kickback Statute is to not require compliance with the one-third procedures test if the joint venture is outside the safe harbor. Requiring divestiture of a physician from the ASC joint venture for failure to meet the one-third procedures test should only be done with advice of legal counsel and in a manner that is applied consistently among all physician investors and that is consistent with the terms of the venture’s Operating Agreement.

Structuring an ASC joint venture in full compliance with the ASC safe harbor may assist the joint venture in making divestiture decisions. Using the ASC safe harbor as a “black and white” test of permissible physician investors does facilitate the removal of physician owners who are not in compliance with the safe harbor standards. In this situation, the one-third income test and one-third procedures test are simply mechanical computations rather than subjective determinations, and physicians who do not satisfy one or both of these tests (as applicable) are divested from the joint venture. In our experience, however, divestiture of physicians is always a politically difficult process and may spawn litigation. For this reason, it is essential that the governing board of the joint venture use great care in structuring its eligible investor standards and reviewing each prospective physician investor prior to admission to the joint venture for compliance with these standards. This will help to eliminate difficult divestiture decisions down the road, or will limit these decisions to situations in which there has been a material change in a physician’s practice or practice patterns.

STARK

Federal legislation commonly referred to as “Stark” further restricts physician referral practices that may have an impact on physician investment in an ASC joint venture. Stark provides that a physician with an ownership or investment interest in, or compensation agreement with, an entity is prohibited from making referrals to that entity for the furnishing of designated health services for which Medicare payments would otherwise be made.¹³ The term “designated health services” initially was defined to include only clinical laboratory services, but the term was expanded in subsequent “Stark II” legislation to include physical therapy services, occupational therapy services, radiology or other diagnostic services, radiation therapy services, the furnishing of durable medical equipment and supplies, parenteral and enteral nutrients, equipment and supplies, prosthetics, orthotics, and prosthetic devices, home health services, outpatient prescription drugs, and inpatient and outpatient hospital services.¹⁴ The prohibitions set forth in Stark are applicable to physician investment in an ASC joint venture to the extent the joint venture will provide designated health services.

Regulations implementing Stark address specific exceptions for ASC’s. Final regulations implementing Stark II became effective on January 4, 2002. These final regulations are being issued in two phases. Phase I (which was issued) addresses certain definitional issues of Stark and specifically provides that services furnished in an ASC are not considered “designated health services” for purposes of Stark to the extent payment for those services is included in the ASC

¹³ 42 U.S.C. §1395nn(a).

¹⁴ 42 U.S.C. §1395nn(h)(6).

payment rate.¹⁵ Services included in the ASC payment rate are those items and services furnished in connection with Medicare’s list of covered ASC services. The ASC payment rate includes reimbursement for “simple” laboratory tests performed just before surgery (e.g. urinalysis and blood hemoglobin or hematocrit). If the ASC is performing more complex diagnostic tests that are not included in the ASC payment rate, the ASC exception to Stark would not apply to these activities.

Phase I of the final Stark II regulations also adds a specific exception allowing implanted prosthetic devices, implanted prosthetics, and implanted durable medical equipment (“DME”) to be performed in a physician-owned ASC, even though reimbursement for those services is not included in the ASC payment rate. Implants, including, but not limited to, cochlear implants, intraocular lenses, and other implanted prosthetics, implanted prosthetic devices, and implanted DME may be provided in an ASC if the following conditions are satisfied: (i) the implant is furnished by the referring physician (or member of his group practice); (ii) the implant is implanted in the patient during a surgical procedure performed in the same ASC where the implant is furnished; (iii) the arrangement for the furnishing of the implant does not otherwise violate the federal Anti-Kickback Statute; and (iv) billing and claims submission for the implant complies with applicable law. While the referring physician may have an ownership interest in the ASC in which the implant procedure is performed, this exception does not cover any financial relationship that the physician may have with the DME supplier.

Phase II of the final Stark II regulations will be issued in the future. Phase II will address the ownership and investment exceptions to Stark and expressly promises to include further consideration of the general exception to the referral prohibition related to both ownership/investment and compensation for services furnished in ASC’s.

FEDERAL TAX-EXEMPTION ISSUES

Legal Overview

The discussion in this section is applicable only to the extent a non-profit, tax-exempt hospital is an investor in the ASC joint venture. A tax-exempt hospital’s participation as an equity owner in a for-profit joint venture raises two federal tax considerations: (i) impact on the hospital’s tax-exempt status; and (ii) the potential that the hospital’s return on investment in the joint venture will be treated as unrelated business taxable income (“UBTI”). These concerns will be minimized if the joint venture is structured in a manner that it operates in furtherance of the charitable purposes and mission of the tax-exempt hospital. This section will discuss what is required in order for the joint venture to be considered a related activity of the hospital that operates in furtherance of the hospital’s charitable purposes.

IRS Joint Venture Guidance. Precedential guidance from the Internal Revenue Service (“IRS”) on the participation of exempt organizations in for-profit joint ventures is found in the following sources:

¹⁵ 42 C.F.R. §411.351.

- (a) Revenue Ruling 98-15 regarding whole hospital joint ventures;¹⁶
- (b) A 1999 Tax Court case, *Redlands Surgical Services v. Commissioner of Internal Revenue*¹⁷; and
- (c) A 2002 federal district court case, *St. David's Health Care System v. U.S.*¹⁸

These legal authorities set forth the standards for whether an exempt organization's participation in a for-profit joint venture is considered related to its exempt purpose. Revenue Ruling 98-15 and *Redlands* state that an exempt organization may form and participate in a for-profit joint venture if such participation furthers a charitable purpose and the arrangement permits the exempt organization to act exclusively in furtherance of its exempt purpose and only incidentally for the benefit of the for-profit participants.

Revenue Ruling 98-15 contrasts "good" and "bad" fact patterns for an exempt organization's participation in a for-profit joint venture that operates a whole hospital. The "good" fact pattern included an exempt organization's participation in a venture where the exempt organization controls a majority of the board and management is by an independent third party. The joint venture's governing documents also required that the venture further charitable purposes by promoting health for a broad cross section of the community and provided that the duty to further charitable purposes overrides any duty to maximize profits. The "bad" fact pattern included an exempt organization's participation in a venture with a 50/50 board and effective control largely in the hands of the private participant through a management contract that could be unilaterally renewed by the manager. The exempt organization did not control the governing board and could not initiate actions to further charitable purposes, and the governing documents of the venture did not obligate the venture to operate for charitable purposes. Only the "good" fact pattern meets the IRS' standards for exemption. While Revenue Ruling 98-15 applies to the joint venture of a whole hospital, the IRS has indicated that the same principles are applicable to ancillary service joint ventures.¹⁹

In *Redlands*, participation in a 50/50 venture similar to the second situation in Rev. Rul. 98-15 was held inconsistent with the participant's exempt status. However, the *Redlands* decision was based on an analysis of a number of facts and circumstances, and the specific facts of *Redlands* were in several respects more troubling than would be the case in most hospital/physician joint ventures. For example, the venture in *Redlands* provided minimal services to Medicaid patients and no indigent care.

In *St. David's*, the District Court for the Western District of Texas overturned the IRS' denial of tax-exempt status for an exempt hospital participant in a whole-hospital joint venture

¹⁶ Rev. Rul. 98-15, 1998-12 I.R.B. 6.

¹⁷ 113 T.C. No. 3 (1999), aff'd, 242 F.3d 904 (9th Cir. 2001).

¹⁸ A-01-CA-046 JN (W.D. Tex. June 7, 2002).

¹⁹ However, it is important to note that a service line joint venture is distinguishable from a whole hospital joint venture in that, with a service line joint venture, the exempt organization continues to provide health care services and other charitable activities independent from the joint venture and, with a whole hospital joint venture, the sole purpose of the tax exempt organization is to own an interest in a joint venture that provides all health care services.

with HCA. The court held that a 50/50 governance structure accompanied by sufficient powers reserved to the exempt participant was sufficient to result in effective control of a “whole-hospital” joint venture by the exempt participant. The court found that majority control is not an absolute requirement, noting various powers reserved to the exempt party and stating that “[t]he government seems focused on majority control, but the law is more concerned with control, regardless of whether its control springs from a majority or from a corporate structure.”

In light of these authorities, the most important factors in determining whether participation in a joint venture furthers the charitable purposes of an exempt organization are whether the exempt organization has sufficient control over the venture to ensure that the venture will operate in an exempt manner and whether the organization actually operates in such a manner. In assessing control, the IRS and the courts will look at all relevant facts and circumstances. Additional significant factors weighing in favor of participation in the venture being an exempt activity are the existence of an obligation to put charitable purposes ahead of nonexempt purposes; the exempt organization can initiate and veto actions that impact charitable purposes; a commercially reasonable management contract (if any) which requires the manager to operate the venture in a charitable manner²⁰; the absence of circumstances creating a potential for private investors to gain competitive advantages through the venture; and the presence of activity, once the venture is in operation, that is consistent with exempt purposes (e.g., significant levels of care to Medicaid and indigent patients).

The Joint Venture as an Unrelated Business Activity. If the venture is not structured in a manner that ensures its operation in furtherance of the charitable purposes and mission of the tax-exempt hospital as described above, then the hospital’s participation in the joint venture will be considered an unrelated business activity and all income derived from the joint venture will be subject to tax as unrelated business income. Whether the tax-exempt hospital’s participation in joint venture also threatens loss of its tax exemption will depend on the size of joint venture’s operations relative to the other tax-exempt activities of the hospital. This analysis is performed on both a qualitative and quantitative basis, and all unrelated business activities of the hospital, taken together, must be analyzed under this concept. The qualitative analysis considers whether the unrelated business activities of the exempt organization are so massive (for example, taking up a large portion of the organization’s time and resources) that it over-shadows the organization’s exempt activities and constitutes the exempt organization’s primary purpose. All of the facts and circumstances of a particular unrelated trade or business activity must be examined to determine if the activity constitutes the organization’s “primary” purpose.

The quantitative analysis considers whether the gross revenues (or receipts) from all unrelated trade or business activities are a substantial percentage of the exempt organization’s total gross receipts. The IRS has never clearly articulated the level of activity or percentage of gross income that will cause the exempt status to be lost. A conservative rule of thumb is to review the unrelated trade or business activities and consider moving them to a for-profit subsidiary to shield the tax-exempt organization when the percentage of gross revenues from all unrelated activities is approximately 15% of the exempt organization’s total gross revenues.

²⁰ The IRS has indicated that it has particular concerns where the manager or an affiliate thereof is also an investor. However, in *St. David’s Health Care System*, the non-exempt party served as sole managing partner, and an affiliate of the non-exempt party managed the venture under a contract with a term of over 52 years.

Fair Market Value Requirements. In addition to the structuring considerations discussed above, IRS standards also require that all of an exempt organization's dealings with private persons are on fair-market-value, arm's length terms.²¹ Failure to meet this requirement could result in revocation of the hospital's tax-exempt status based on a determination that the dealings resulted in private inurement or more than insubstantial private benefit.²² This requirement also applies to dealings between the hospital and the venture and between the venture and private persons (since the hospital's share of the venture's activities is attributed to it). All of these arrangements must be on fair market value terms.

STRUCTURING A JOINT VENTURE TO COMPLY WITH FEDERAL TAX-EXEMPTION ISSUES

Operation of the Joint Venture in Furtherance of Charitable Purposes

Even though the venture itself is a for-profit entity, it must operate in furtherance of the charitable purposes of its tax-exempt hospital partner. As a practical matter, this will require the venture to operate in the following manner:

- (a) The venture must offer and provide its services to a broad cross section of the community.
- (b) The venture must be founded on the guiding principle that charitable purposes will override profit motives in the event of any conflict between the two, and the governing board must operate the venture in furtherance of this guiding principle.
- (c) The venture must adopt and implement a charity care policy that is similar to that of the hospital, and should monitor the level of charity care provided and compliance with the policy on a regular basis. The charity care policy should be made known to staff, patients and the community. It may be desirable for the venture, prior to making distributions to its members, to fund a charity care account for use by the venture in providing charitable health care services.

²¹ The Internal Revenue Service defines fair market value for these purposes as follows:

The fair market value of property, including the right to use property, is the price at which property or the right to use property would change hands between a willing buyer and a willing seller, neither being under any compulsion to buy, sell or transfer property or the right to use property, and both having reasonable knowledge of relevant facts.

63 Fed. Reg. 41486, 41501 (August 4, 1998). (This definition, contained in proposed regulations under the excess benefit transaction taxes under Code Section 4958, restates the standard IRS definition of fair market value.)

²² In addition, physicians who are deemed "disqualified persons" may be subject to excise taxes on the excess value received and to mandatory repayment of that value to the hospital. "Disqualified persons" are those who have or within the past five years have had the ability to substantially influence the affairs of the organization; whether physicians are "disqualified persons" depends on the facts and circumstances. See Prop. Treas. Reg. 53.4958-3 (setting forth factors to consider in determining disqualified person status).

(d) The venture must participate in the Medicare and Medicaid programs and provide services to all persons needing care in a non-discriminatory manner and without regard to ability to pay.

(e) The venture must maintain an open medical staff.

(f) Any third party management company engaged by the venture should be contractually required to operate the venture consistent with the charitable purposes set forth in the venture's Operating Agreement, and variable compensation should be structured in a manner that does not create disincentives to further charitable purposes.

(g) The venture must adopt and implement an appropriate conflict of interest policy.

In order to evidence that its participation in the venture is consistent with its exempt mission, a tax-exempt hospital participant should document both its charitable purposes for entering into the transaction and its ongoing monitoring of, and actions to ensure the venture's ongoing compliance with, requirements imposed to further those purposes.

Hospital Control Model. As noted above, the risks of the venture to the tax-exempt hospital will be minimized if the hospital has control over the venture. The hospital could establish such control by obtaining a majority ownership interest in the venture and having a majority position on the venture's governing board. The hospital would exercise its authority through directives to the hospital employees or board members who are appointed to serve on the management board. In order for this to work effectively, the hospital should have the ability to remove the managers that it appoints at any time, and the voting mechanism should not allow a manager's absence to result in a loss of control.

Although the hospital would generally control the operations of the venture under this alternative, governance of the venture could be structured in a manner that requires (subject to the hospital's reserve powers) the presence of a predetermined number of physician-elected managers for a quorum needed for management board action. In addition, the Operating Agreement could provide that certain fundamental decisions (*e.g.*, merging or selling the venture entity or its assets; requiring additional capital contributions; admitting new physician members; amending the venture's Operating Agreement; establishing a joint venture with another entity; establishing budgets; approving third party management agreements; changing the scope of services provided; borrowing money; and dissolution of the venture entity) would require approval of a supermajority of the members and/or the managers that will be obtainable only with physician support. This approach would provide physician investors with a significant voice, particularly if major business decisions require a supermajority vote.

We do not believe that allowing these provisions would present a risk to the hospital's tax-exempt status or a significant risk of the hospital's allocable share of income from the venture being UBTI, so long as provisions are built into the Operating Agreement permitting the hospital to override these provisions where necessary to protect its tax-exempt status, avoid UBTI, and prevent other legal violations.

50/50 Governance Model. Because absolute control may not be acceptable to a sufficient number of prospective physician investors, we have also noted potential modifications that would impose minimal risk to the hospital's tax-exempt status,²³ and would still allow the hospital to take a reporting position that income from the venture is not UBTI (although there is a somewhat greater risk that the IRS could successfully impose unrelated business income tax if these modifications are made).

Physician investors may be reluctant to invest on terms providing for majority hospital ownership and control. Often, the physicians will desire to be the majority owner and will want to have a controlling representation on the governing board. Typically, a middle ground can be reached with the physicians (collectively) and the hospital each owning 50% of the venture and having 50% of the vote on the governing board. In a 50/50 governance structure where the hospital does not control the governing board, it is essential for the hospital to have the unilateral, unfettered right to exercise powers sufficient to ensure ongoing exempt operations through reserve powers. Through its reserve powers, the hospital should have the ability to veto or initiate any actions that are necessary to ensure that the venture operates in furtherance of the charitable purposes of the hospital. The hospital should also be able to exit the venture and receive fair market value for its interest or dissolve the venture if necessary to protect its exempt status or to prevent other legal problems.

It is important to note that, while governance rights may be proportionate to equity ownership (e.g., a 51% ownership interest translates into a 51% voting authority on the governing board), in an LLC structure it is not essential that governance follow equity. This may be beneficial for the venture in which the physician group insists on owning more than 50% of the venture, but the hospital needs governance control to avoid UBTI and to protect its tax-exempt status. In such a situation, the hospital could be a minority owner, but still have equal representation and voting rights on the governing board and appropriate reserve powers to protect its tax-exempt status. A hospital should not have less than 50% governance rights in order for the hospital to take a reporting position that income from the venture is not UBTI.

In negotiating the hospital reserve powers, it is preferable for the hospital to have sole discretion in the exercise of its reserve powers, and this often can be successfully negotiated through the balance of power given to physicians on certain issues important to the physicians (e.g., clinical issues, staffing and scheduling, distributions). However, it may be necessary to agree on a dispute resolution process to resolve a disagreement on whether exercise of the reserve power is appropriate under the circumstances. For example, the parties could agree to enter into a non-binding mediation process to consider whether a mutually agreeable alternative approach is available. If the dispute is not resolved through non-binding mediation, a conservative approach that would minimize the risk to the hospital would require the hospital's position on the disputed matter to prevail, provided this position is determined necessary by an opinion of qualified legal counsel to the hospital. However, based on our experience, these points are generally heavily negotiated and often lead to dispute resolution procedures or buyout terms that are less favorable to the hospital participant. The degree of UBTI risk would depend upon the precise terms negotiated.

²³ This assumes that the hospital does not have other nonexempt activity that, when combined with the venture's activity attributed to it, results in its aggregate nonexempt activity exceeding IRS limits.

Physician Control Over Clinical Issues. Under both the hospital-control model and the equal governance (subject to reserve powers) model, physician investor representatives could maintain control over certain defined clinical matters (subject to the ultimate authority of the venture's management board and the hospital's reserve powers). This can be accomplished by establishing a clinical operations committee and defining its responsibilities in the venture's Operating Agreement. Areas that we typically reserve to such a committee include surgery scheduling, medical staff credentialing (subject to the venture's open staff requirements), quality assurance, utilization management, training and education of clinical support staff employees, and equipment selection within approved budgets. The hospital would have the power to prevent the physician investor representatives from controlling clinical matters in cases where the matter is likely to have a material adverse financial effect on the venture or require a material financial commitment by the venture.

VALUATION ISSUES

It is important for legal compliance that any non-cash assets contributed by a party to a joint venture be appropriately valued and that the party receive fair market value for these assets. For example, if a hospital is contributing all or a portion of its outpatient surgery business to an ASC joint venture, the business being contributed (tangible and intangible assets) should be valued and the hospital should receive fair market value for its assets. Failure to appropriately value these assets raises legal issues under the Anti-Kickback Statute as well as private inurement and private benefit issues if the hospital is a tax-exempt organization.

The IRS' Continuing Professional Education (CPE) Technical Instruction Program for FY 2002²⁴ contains the following discussion of valuation in the context of hospital joint ventures with private parties:

A proper valuation of interests is essential in determining that ownership interests of the tax-exempt organization in the joint venture are proportionate to and equal in value to what it has contributed to the joint venture. Otherwise, the for-profit entity might receive undue private benefit from the transaction. If the tax-exempt hospital or health care provider contributes assets other than cash to a joint venture, it should obtain a certified appraisal by an independent third-party appraiser to ensure its contributions are valued appropriately. The tax-exempt hospital or tax-exempt health care provider should be credited with the value of any existing business contributed, including the value of the income generated by the facility. Only then can the tax-exempt hospital or health care provider evaluate if the joint venture is an appropriate way to achieve its charitable purposes, or if the transaction will provide more-than-incidental private benefit to the for-profit partners.

The value of the existing line of business that is being contributed by the hospital through entering into the venture and its non-competition obligations should be determined by a qualified

²⁴ The CPE is an internal IRS training handbook that is published annually to provide guidance to the public on specified tax topics. The CPE is not precedential guidance, but provides a valuable indication of the IRS' current position on a variety of tax issues. Guidance of this type is particularly useful in the healthcare field because of the relative paucity of precedential guidance.

appraiser. Legal counsel should coordinate with the appraiser to ensure that the valuation is performed consistent with IRS guidelines. The following points will be relevant to this analysis:

(a) The value of a business is typically determined primarily by reference to discounted after-tax anticipated cash flows, sale prices of comparable businesses, and replacement cost of business assets, with the cash flow analysis typically receiving the greatest emphasis. The value of a business beyond the value of its tangible assets represents the goodwill of that business. In evaluating the goodwill value of the outpatient surgery business, the alternative opportunities of potential investors to enter into other ventures and the likelihood that the hospital would retain the existing business contributing to anticipated cash flows are relevant.

(b) There may be a transfer of goodwill value in some cases even where no tangible assets are being transferred (for example, where a hospital agrees to reduce its operating room capacity in order to facilitate the venture obtaining a certificate of need). The analysis should take into account whether in substance anything of value (whether tangible assets, intangible rights or both) is being transferred from a party to the venture.

(c) To the extent that the physicians have the ability to form an ambulatory surgery center venture without the hospital's participation or cooperation or to enter into a competing venture, the value of hospital's existing line of business is reduced. The impact of the hospital's participation on the likelihood of CON approval, if applicable, is relevant to this analysis.

SECURITIES LAW ISSUES

The venture will issue equity interests to the hospital and the physician investors, who will be admitted as members of the joint venture. The offering of such interests will be subject to regulation under both federal and state laws relating to the offering and sale of securities.

Under federal and state securities laws, an offering of securities must be registered with the Securities and Exchange Commission (the "SEC") and appropriate state securities commission unless the securities or the offering is exempt from registration. Registration is costly and time consuming and, therefore, the venture will want to avoid registration of the offering of its equity interests. In general, if the offering is conducted so that it is exempt under the federal rules, it will also be exempt from registration with the applicable State.

The equity interests will not be securities automatically exempt from registration. Therefore, in order to avoid registration, they must be offered by the venture in a manner not involving a "public offering." This is the so-called "private placement" offering exemption. In order to qualify for this exemption the following conditions must be met:

(a) There can be no more than 35 purchasers of the venture's equity interests. (There are a number of rules used to calculate the number of purchasers that will have to be considered once the offering is structured.) In addition, offerings made within six months of each other will be treated as a single offering and the 35-purchaser limit will apply to the entire integrated offering. However, for purposes of this limitation, investors who qualify as "accredited investors" do not count toward the 35-purchaser limit.

Individuals can be accredited investors if (i) such individual, along with his or her spouse, has a net worth of more than \$1 million, (ii) such individual had an income of more than \$200,000 (or \$300,000 with his or her spouse) in each of the last two years and reasonably expects to have an income at such levels in the current year or (iii) such individual is an officer or director of the issuer. Entities may be accredited investors if all of the equity owners are accredited investors or if the entity has assets in excess of \$5,000,000 and was not formed for the sole purpose of acquiring the investment interest.²⁵

(b) Any investor who is not an accredited investor must be able to demonstrate that he or she, either alone or with a qualified “purchaser representative” (e.g., licensed broker or investment advisor), has sufficient knowledge and business experience to be able to analyze the merits and risk of investing in the venture. In order to make this determination, the subscription agreement to be signed by investors should elicit information about the investors and/or their representatives relating to their ability to analyze the merits and risk of the proposed investment.

(c) The offering cannot involve any type of “general solicitation.” This means that no form of advertisements regarding the offering can be used. The SEC has also taken the position that in order to avoid a general solicitation, offers may only be made to persons with whom the issuer has a “pre-existing relationship”. In general, such a relationship should exist for physicians on the hospital medical staff or who have some other prior affiliation with the hospital.

(d) The venture will be required to provide appropriate disclosure materials to purchasers. This is done by the Private Placement Memorandum (“PPM”). Any information (including oral information) used in connection with the offering of the venture’s equity interests must be consistent with the PPM and should be reviewed by counsel prior to use. The PPM will include a detailed discussion of the terms of the offering, the legal structure and governance of the venture, disclosure of the potential risks associated with investing in the venture and an overview of the venture’s financial projections.

(e) Financial projections and other types of “forward looking statements” used in connection with the offering are a source of potential liability if they turn out to be materially different from actual results.²⁶ Therefore, this type of disclosure must be carefully drafted and based on reasonable and fully disclosed assumptions.

(f) In addition to the PPM, each investor must be given the opportunity to ask questions and receive answers about the venture a reasonable time prior to the closing of the offering.

²⁵ There are a number of other classifications of accredited investors, but these are the only ones potentially applicable to physician investors.

²⁶ These types of forward-looking statements are not protected under recent changes to the liability provisions of federal securities laws.

(g) A notice on “Form D” must be filed with the SEC within 15 days of the first sale and with the applicable State at some point prior to the first sale. This is a standard “fill-in-the-blanks” type form.

In order to ensure compliance with a number of these requirements, each investor will need to complete a subscription agreement. Among other things, the subscription agreement will contain a certification that the investor is an accredited investor, or if not, that he or she is otherwise qualified to invest.

A PPM must also be prepared for subsequent offerings of investment interest in the joint venture. If the subsequent offering occurs after the joint venture has commenced operations, the disclosures and financial information reported in the PPM must be appropriately updated and supplemented. The disclosure obligations are more flexible to the extent the joint venture is offering solely to accredited investors.

ANTITRUST ISSUES

There are a number of antitrust issues that could potentially arise with ASC joint ventures, but a key issue may arise with the inclusion of the ASC joint venture in the hospital’s network for purposes of negotiating managed care contracts. The antitrust laws prohibit price fixing among competitors, and the ASC will be considered a competitor of the hospital for antitrust purposes unless the hospital owns at least a majority (perhaps more) of the ASC and has governing control.

The basis for this legal analysis is founded with the Supreme Court’s decision in *Copperweld* which, in very general terms, adopted an intra-enterprise conspiracy “exception” for a parent and its wholly owned subsidiary (*i.e.*, a parent and subsidiary cannot conspire to fix prices). In the *Copperweld* case, the Supreme Court said it was not deciding if and when the rule could apply to a “not completely owned” affiliate entity. Some lower courts have reasoned that *Copperweld* was based on the Supreme Court finding that a parent could control its wholly owned subsidiary, and have applied the rule to 51%+ subsidiaries on this basis; others courts have said it is a full common ownership rule and have rejected anything less than 100% ownership or its virtual equivalent. On this basis, it would be difficult for a hospital to have contracting authority over the ASC joint venture unless the hospital had, at a minimum, 51% equity ownership and control over the governing board on most issues.²⁷

PROCESS AND TIMELINE

The success of forming an ASC joint venture is largely dependent upon process and timing. We recommend that parties take the steps set forth below. Our experience indicates that the process of negotiating and forming the joint venture should be able to be accomplished within about a six-month period, although this can be shorter or longer depending upon the focus of the parties and the issues that arise.

(a) Engage ASC consultant for feasibility analysis.

²⁷ This issue should be reviewed by counsel on a case-by-case basis. The applicable legal standards may vary depending on the jurisdiction in which the joint venture is located.

- (b) Form steering committee comprised of hospital and physician representatives that have authority to speak for the groups they represent.
- (c) Engage legal counsel to assist in the process.
- (d) Enter into a confidentiality agreement and/or letter of intent, as appropriate.
- (e) Engage valuation firm to conduct any necessary appraisals.
- (f) Begin development of a term sheet that outlines the material terms of the joint venture. This term sheet should be relatively detailed and should form the basis for negotiation among the parties on key issues such as equity ownership, governance, non-competes, etc.
- (g) Once the term sheet has been agreed upon, a draft of the Operating Agreement will be prepared that incorporates the terms set forth in the term sheet. The Operating Agreement should be shared with the prospective physician investors and negotiated by their representatives. It is important for the hospital and prospective physician investors to negotiate and agree to the terms of the Operating Agreement prior to the offering. This is a difficult process to manage unless the physicians are working through a group of physician representatives and, preferably, a single legal counsel.
- (h) After the Operating Agreement has been finalized, the PPM is prepared and the offering commences. The offering generally remains open for 60-90 days, depending on applicable time constraints. A PPM and formal offering may not be required if the transaction is a negotiated transaction between the hospital and certain identified physicians that have been actively involved in the development and negotiation of the transaction.

FURTHER INFORMATION

For further information on ASC or other hospital/physician joint ventures, please contact Robert Cohen at (402) 231-8738 or Jennifer Brown at (479) 973-4200.