Strategic Deals and Innovative Business Arrangements for Health Care Organizations

Health Law Webinar

January 8, 2025

Our Agenda

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Physician Practice Transactions

- Introductions
- Big Question:
  - To Sell or Not to Sell?
- Options for Remaining Independent

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Motivations

- Recruitment Challenges
- Overhead and Decreasing Reimbursement
- Health Care Reform
- Access to Capital
- Perception of Greater Security
- Reluctance of New Professionals to Buy-In

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Consolidation: Pros and Cons

- Pros:
  - Protect incomes
  - Help with recruitment
  - Avoid hassles of owning a practice
  - Focus on practicing medicine

- Cons:
  - Lack of autonomy and independence
  - Frustration with inefficiencies
  - If the transaction doesn’t work, it will be very difficult to “reverse” the deal
  - Future financial pressures facing hospitals due to health care reforms and declining Medicaid/Medicare reimbursement; more consolidation likely
  - Nonprofit/governmental hospital requirements (e.g., open meeting laws, fair market value compensation)

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Remaining Independent

- Practice Basics Options
  - Increase Size
    - Organic growth through recruitment
    - Merge
  - MSOs
  - Joint Ventures
  - Strategic Alliances
  - PSAs/MSAs
  - Ancillaries/ASCs

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Practice–Owned ASCs

Practice-Owned ASC's

- Practice can own equity in ASC's
  - Directly or through holding company
- Net income paid to physicians via practice compensation model
  - Many options (production-based compensation, for example)
- ASC value can be included in redemption formula
- What about 1/3rd tests?
  - AKS Employee Safe-Harbor
- Benefits: interests better aligned, contracting, recruitment

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Physician Supergroups

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“Supergroups”

- Typically, a group of physician practices under a single EIN and legal entity
- Single or multi-specialty
- Structure options vary, but typically include divisions or “care centers”
- May include an MSO structure
- Varying levels of integration

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Pros and Cons

- Pros:
  - Better negotiating/political clout
  - Economies of scale
  - Better administrative help
  - Ability to offer more ancillaries
    - More legal flexibility
    - More economic flexibility
  - Public may perceive bigger as better

- Cons:
  - If a division is unable to pay its liabilities, divisional “firewall” might be breached
  - Loss of individual autonomy

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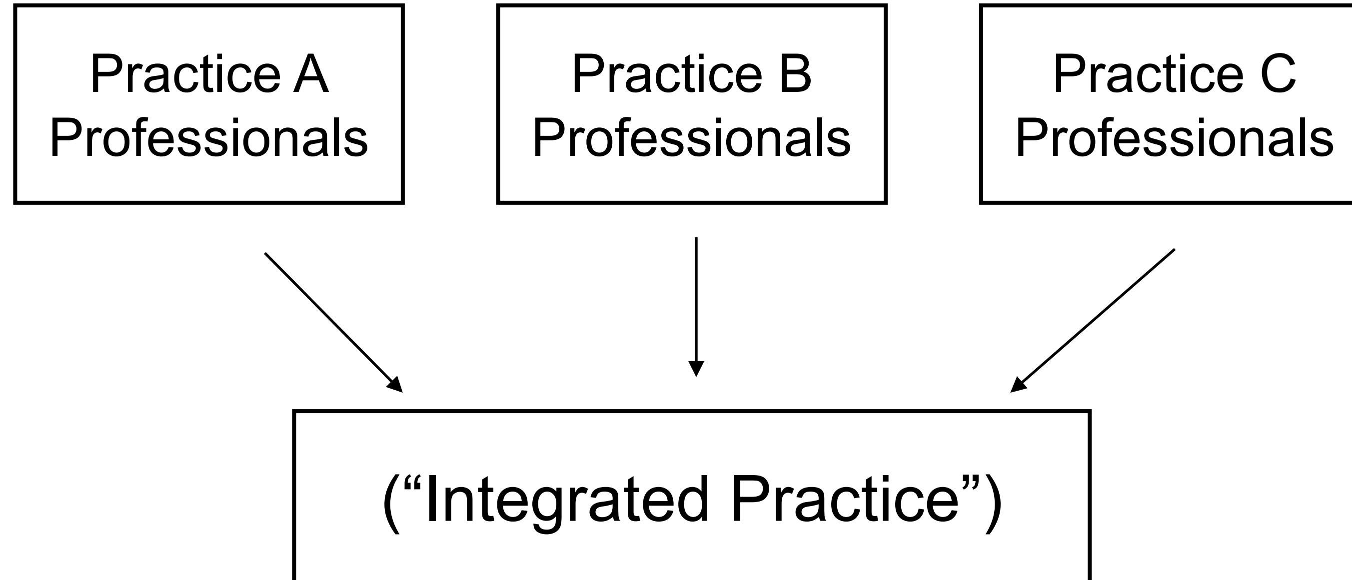
Divisional Merger Structure



- Physicians become owners of the Integrated Practice
- Practice assets/liabilities become asset/liabilities of new Integrated Practice divisions

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Divisional Structure

- Each division operates as its own profit center
- Physician agreements
- Benefits
- Indemnification

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Governance

- Board of Directors
  - Each division represented
  - Manages and maintains control over matters affecting corporation as a whole
- Divisional Boards/Advisory Committees
  - Membership determined by the division
  - Manages division’s day-to-day operations and makes recommendations to the Board of Directors regarding significant matters

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Regulatory Considerations

- Stark
  - Ancillaries
  - Group Practice
  - Compensation Methodologies
- State Law/Cross-Border Implications
- Antitrust

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Hospital/Health System Investment in Practice

- Separate class of stock/division
- Stark "group practice" requirements
- Other considerations…

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Innovating through Partnerships

- Collaborating with Start-Ups
- Health/Tech Arrangements
- Other

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Regulatory Issues

- Antikickback
- Stark
- Antitrust
- Tax exemption (for nonprofit tax exempt organizations)
- Corporate practice/licensing
- HIPAA/privacy laws

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Private Equity in Healthcare

- Health systems and other health care providers are increasingly looking to expand and strengthen their services and resources through partnerships with PE, VC and other for-profit investors
- PE investors are increasingly looking for opportunities with health systems and providers to commercialize successful and/or promising products and services of those systems

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Private Equity in Healthcare – Increased Scrutiny

- In March 2024, FTC, DOJ and HHS issued a Request for Information on Consolidation in Health Care Markets
- Held a joint workshop to discuss private equity's involvement in health care
- Proposed federal legislation – Health Over Wealth Act and Corporate Crimes Against Health Care Act
- Federal Trade Commission v. U.S. Anesthesia Partners, Inc.

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Private Equity in Healthcare – Considerations in Choosing a Partner

- Who is the buyer?
- What is the buyer’s track record?
- How will the practice be operated?
- What is the exit plan?

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Private Equity in Healthcare – Common Deal Issues

- Deal Structures
  - Platform v. add-on transactions
- Purchase Price
  - Rollover equity?
  - Earnout?
- Employment/Compensation
- Restrictive Covenants

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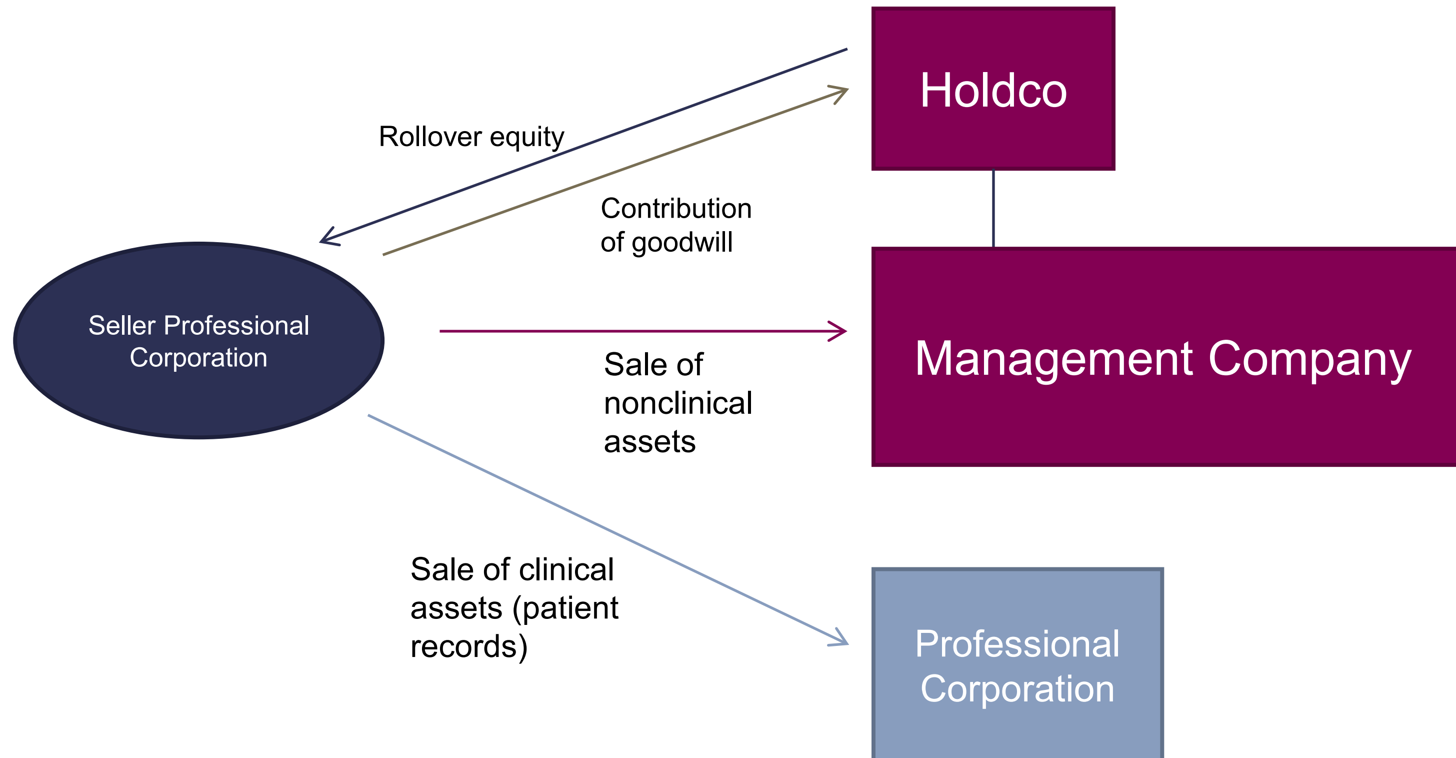
Private Equity in Healthcare – Sample Acquisition Structure



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Private Equity in Healthcare – Corporate Practice of Medicine

- Corporate Practice of Medicine (“CPM”) Prohibition
  - Prohibits corporations from employing professionals or owning professional practices
  - Applies to many disciplines (e.g., dentistry, nursing, veterinary)
- Need to consider when partnering with PE or other strategic investor

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Private Equity in Healthcare – Corporate Practice of Medicine

- Potential Ramifications for Violating the CPM Prohibition
  - Injunction against continued operation
  - Criminal prosecution
  - Impact on professional's license
  - Arrangement is voided
  - Refusal to pay claims
  - Loss of "private practice", "physician office" and similar exceptions from state licensing requirements

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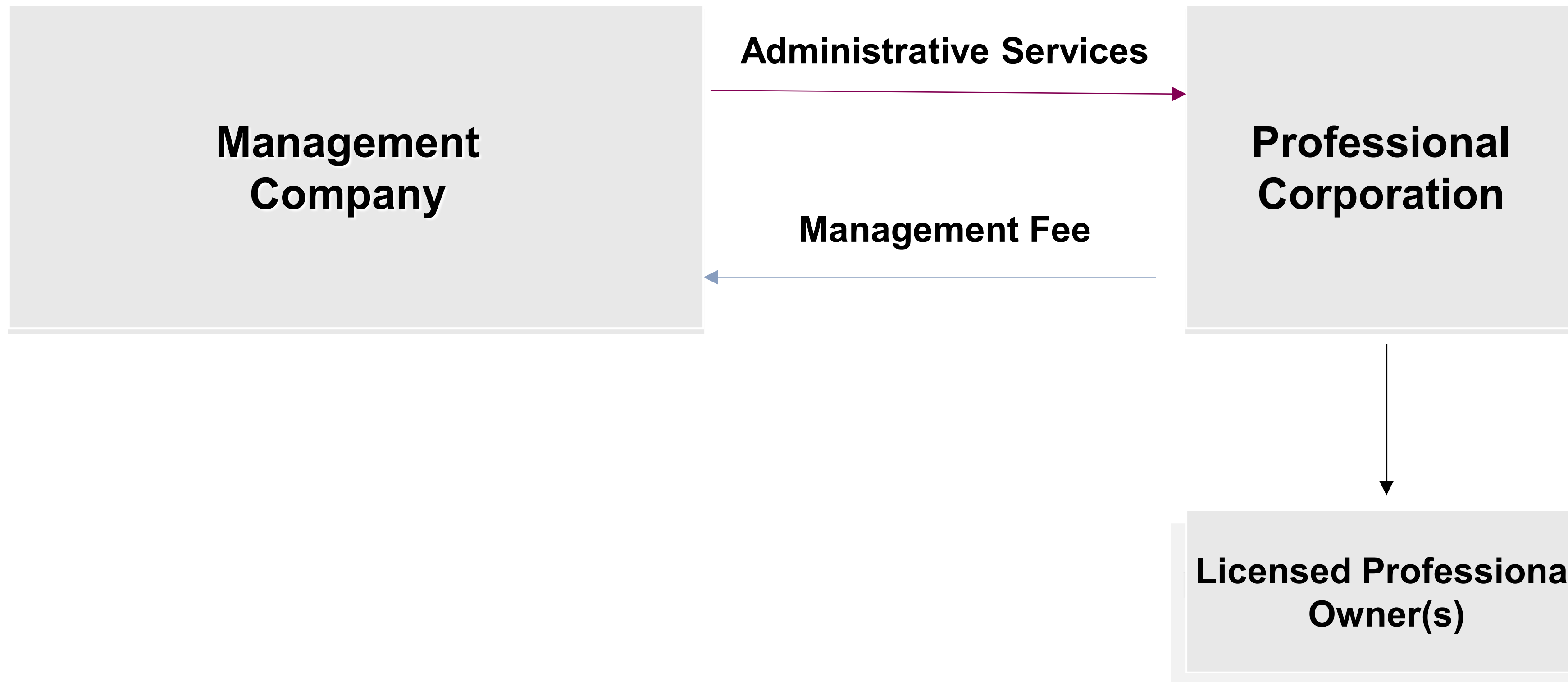
Private Equity in Healthcare – MSO Arrangement



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Physician Hospital Joint Ventures

- Enterprise in which two or more parties
  - Integrate their operations
  - Have joint control over enterprise
  - Make substantial contributions
  - Often for a limited and specific purpose
- Allows competitors to collaborate

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Physician Hospital Joint Ventures

- Contractual
  - E.g., leasing arrangements, management services
- Equity
  - Joint ownership of entity
  - E.g., ambulatory surgery center
- Hybrid
  - Joint ownership with various contractual arrangements between JV entity and owners
  - E.g., ambulatory surgery center

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Physician Hospital Joint Ventures – Tax Exemption Issues

- Tax-exempt health systems (and other tax-exempt entities) must comply with a host of restrictions and obligations from the IRS and state authorities
- Section 501(c)(3) provides tax exemption for corporations organized and operated exclusively for charitable, scientific, or educational purposes, so long as no part of the organization’s net earnings inure to the benefit of any private shareholder or individual
- The promotion of health for the benefit of the community is a charitable purpose

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Physician Hospital Joint Ventures – Tax Exemption Issues

- No Private Benefit/Inurement
  - Exempt organization needs to ensure transactions are fair market value
    - Contributed assets
      - Including value of any contributed existing business
    - Valuation (consider having legal counsel engage valuation firm)
- Exempt organization must have formal or informal control over the joint venture sufficient to ensure furtherance of charitable purposes

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Health Privacy Implications and Risks

- Privacy considerations impact diligence, deal structure, indemnification, and transition activities
- Regulatory Landscape:
  - HIPAA
    - Transfer of PHI: PHI may be disclosed in a “sale, transfer, merger, or consolidation of all or part of the covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity.”
  - Information Blocking
  - 42 CFR Part 2
  - Non-PHI/Consumer Health Data
  - State Law

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Commercializing Data

- Data is viewed as a critical corporate asset (and liability)
- Many transactions now have data as a key component
- Such transactions require navigating complex IP, regulatory and privacy issues, including:
    - Complying with HIPAA
    - Complying with evolving state-specific laws
    - Complying with 3rd party terms

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Value Based Care Arrangements

- Broad umbrella of arrangements between medical providers, manufacturers, and payors shifting from fee-for-service payment toward quality and cost accountability
- Incentivizing quality in health care is not new
- Historically, CMS attempted to incentivize the shift to value-based care through CMS-supported programs with corresponding regulatory waivers (e.g., MSSP, BPCI, etc.)
- Terminology has varied greatly (and continues to vary), but has recently focused on definitions within the applicable exceptions and safe harbors under Stark and the Anti-Kickback Statute

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Regulatory Safe Harbors and Exceptions

- CMS and OIG issued value-based care exceptions (for Stark) and safe harbors (for the Anti-Kickback Statute) to help incentivize the shift on a broader scale.
  - Certain arrangements may otherwise have been prohibited under Stark and/or suspect under the Anti-Kickback Statute
  - Exceptions and safe harbors are definition heavy
  - Differentiates based on the level of risk: (1) low risk "value-based arrangements" or care coordination arrangements; (2) meaningful or substantial downside financial risk; and (3) full financial risk
  - Must be a "value-based participant" in a "value-based enterprise"

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VBE (Defined)

- Value-based enterprise. Two or more VBE participants:
  - Collaborating to achieve at least one value-based purpose;
  - Each of which is a party to a value-based arrangement with the other or at least one other VBE participant;
  - That have an accountable body or person responsible for the financial and operational oversight of the value-based enterprise; and
  - That have a governing document that describes the value-based enterprise and how the VBE participants intend to achieve its value-based purpose(s).
- 42 CFR § 411.351

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VBE – In Practice

- VBEs do not need to be separate legal entities
- VBEs may take the form of a CIN (or other physician network), ACO, or separately established legal entity to manage and administer value-based care arrangements between parties
- Tied to specific and identified “target patient populations”
- Structure must conform to applicable Stark exception, if applicable, and should fit as closely with AKS safe harbor as possible

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Outcomes-Based Payment Safe Harbor

- AKS safe harbor carves out “outcomes-based payment” from the definition of remuneration, under certain conditions, including:
  - Agent must achieve one or more legitimate outcome measures that:
    - Are selected based on clinical evidence or credible medical support; and
    - Have benchmarks that are used to quantify: (1) Improvements in, or the maintenance of improvements in, the quality of patient care; **and/or** (2) A material reduction in costs to or growth in expenditures of payors while maintaining or improving quality of care for patients.
  - Requires regular monitoring and assessment, along with policies to addressed and correct material performance deficiencies
- Certain parties cannot use this safe harbor (e.g., pharmaceutical companies, PBMs, laboratories, DMEPOS)

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Corporate Transparency Act

- Effective January 1, 2024
- Reporting required for newly formed Reporting Companies beginning 1/1/24
- Deadline for existing Reporting Companies to report was 12/31/24
- 5th Circuit reinstated nationwide injunction blocking enforcement on December 26, 2024, with oral argument scheduled for March 2025

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Who Is Required to Report

- All Reporting Companies, unless an exemption applies
- Twenty-three categories of exemptions but a few a more likely to apply:
  - Large operating companies (more than 20 FTEs, physical operating presence in the US, and >$5 million in domestic gross receipts on last tax return)
  - Tax-exempt entities (including nonprofit organizations described in 501(c) of the IRC and exempt from tax under 501(a))
  - Public companies
  - Subsidiaries of certain exempt entities

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What Must Be Reported

- Information about the Reporting Company:
  - Legal name, registered trade name or d/b/a, address of principal place of business in the US, jurisdiction of formation and TIN
- Information about Beneficial Owners and Company Applicants:
  - Full legal name, date of birth, complete address, unique identifying number from government issued identification, and an image of the ID
- Information must be updated when changes occur
- Civil and criminal penalties for noncompliance

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Northern Lights

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Healthcare Transactions Laws

- These states have laws on the books: California, Colorado, Connecticut, Hawaii, Illinois, Indiana, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Vermont and Washington
- Legislation to bolster existing law is pending in Massachusetts
- Laws failed to pass recently in California (vetoed by the governor) and Minnesota

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Healthcare Transaction Laws Issue Spotting

- What entities or individuals are subject to the law?
- What kinds of transactions are covered?
- What needs to be disclosed? And to whom?
- When do I need to make the disclosure?
- Is there a consent requirement or just notice?

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What’s the Deal with Non-Competes?

- FTC’s nationwide rule was enjoined
- State-specific laws becoming more common
- Typically a carveout for sale of a business but varies after that
- Don’t forget about case law
- Bolster confidentiality and non-solicitation requirements
- Additional strategies may be available

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