Becker's ASC Review

Ambulatory Surgery Centers

BUSINESS AND LEGAL UPDATE

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RESTRUCTURING OF SURGERY CENTERS

Several trends have emerged that often lead to the restructuring of ASCs. Briefly stated, as ASCs have increasingly become "extension of practice" providers, three key factors regularly require ASCs to be restructured. First, physicians invested in ASCs have aged, have retired or passed away. Second, key physicians have departed. They have either relocated or attempted to form their own ASCs. Third, ASCs have found themselves unable to bring in new physicians. These factors have motivated several ASCs to try to restructure their companies. In connection with numerous projects, we have developed a number of core concepts related to such restructurings. A number of these core concepts are set forth below.

First, it is much easier to restructure an ASC when the ASC is operating fairly well. Once the ASC begins to struggle and is in a position where it needs to bring in new cases and/or investors, it will experience more difficulty in attracting new physician investors to the ASC. Many outside physicians enjoy nothing more than watching an ASC formed by other competitor physicians struggle and perhaps become unviable.

Second, it is much easier to attract new investors when an ASC is paying its owners distributions as opposed to requiring capital calls. The distributions need not be large. Nor do they need to generate a high return on investment. However, investors trust the delivery of actual dollars as opposed to the delivery of financial statements that show that money is being earned.

Third, as part of a restructuring, it is typical to revise the governing documents of the ASC to include provisions that require the ASC to adhere to the safe harbor to the Federal Anti-Kickback Statute for ASCs. These include both qualitative and quantitative tests. The ASC safe harbor, if properly implemented, can help improve the legal defensibility of the venture.

Fourth, as part of a restructuring, it is typical to use the opportunity to buyout retired physicians and other physicians who do not comply with the ASC safe harbor. If the governing documents of the ASC do not provide a means by which to buyout such physicians, an ASC will often be forced to buyout such physicians at a premium in order to avoid legal conflicts with such physicians.

Here, as part of the restructuring, an ASC may attempt to buyout physicians who do not meet the ASC safe harbor and who otherwise are no longer involved with the ASC due to retirement, relocation or various other reasons. Where the ASC has not accounted for such circumstances in its initial governing documents, the ASC must engage in a two-part process to buyout such physicians. First, it may amend the governing documents to change the eligibility requirements for investors. Second, the physicians who comply with the ASC safe harbor may directly work together with the noncompliant physicians to buy them out. Even where the ASC has the right to change the eligibility requirements, it is often prudent to pay such physicians a premium in order to avoid litigation and disputes with such physicians. Generally, the cost of litigation far outweighs the benefits of freezing out a physician at a reduced price. In one case, an ASC and its managing partner were found liable for punitive damages in the amount of several million dollars due to an alleged freeze out scheme.

Fifth, it is typical as part of a restructuring, and as part of the development of ASCs today, that an ASC will include a covenant against competition in its governing documents. The covenant against competition will not prohibit physicians from providing services at other facilities. It will, however, limit the physicians from acquiring ownership or investment interests in other ASCs within a certain radius of the ASC. In the excitement of developing a center, many ASCs were formed without covenants against competition. In many cases, where an ASC became very successful, physicians left the ASC to develop their own ASC.

Sixth, a key part of a restructuring is often engaging in an effort to attract new physicians. Additional physician investors add stability to the ASC and help protect the capital base of the ASC. Typically, each new physician (a) will buy a minority and non-controlling interest in the ASC, (b) will pay an amount equal to fair market value for the ownership interests that he or she purchases, and (c) will agree to abide by the governing documents of the ASC, including a non-competition covenant and the requirements set forth in the ASC safe harbor. Each physician will also agree to withdrawal provisions that require a physician to be redeemed upon the occurrence of certain events.

Seventh, a general rule of thumb is that an ASC should have approximately five to six full-time employees for each one thousand patients that it serves. If a staffing ratio is significantly out of balance, it makes sense to review whether the staffing of the ASC should be changed. It also makes sense to look at alternatives, such as using part-time staff and implementing a schedule pursuant to which the ASC operates during only certain days of the week.

Eighth, in certain situations it makes sense to restructure the debt of the ASC. Here, there are situations where debt can be restructured at lower interest rates or in a manner that prolongs the payment schedule. While it is better to have no debt, there are times where prolonging the payment schedule can allow an ASC to make distributions.

Ninth, ASCs increasingly have options with respect to managed care contracts. It makes sense for ASCs to approach payor contracts with a much sharper review than they did several years ago. For example, if an ASCs has a managed care contract that pays less than Medicare rates or less than 120% of Medicare rates, it may make sense to work without such contracts. This has to be evaluated on a case-by-case basis. For example, the ASC must examine its ability to operate out-of-network and to work with its physicians with respect to out-of-network patients. Also, an ASC must evaluate what percentage of the ASC's revenues are accounted for by such contracts.

Should you need assistance or the recommendation of a company to assist your ASC, please contact Scott Becker at (312) 750-6016 or Email at sbecker@mcguirewoods.com.

TWENTY TO WATCH

In our last ASC Review, we named 20 companies to watch in the coming year. Here are three additional companies to consider.

First, *Universal Surgical Services*. Universal Surgical Services is a subsidiary of Universal Health Services. Over the last several years, they have moved from having just a couple of centers to more than a dozen. They are careful buyers of ambulatory surgery centers and compliment the general business of Universal Health Services well. Both Michael Urbach and Alan Hale have been at the company for a long time and have made a substantial effort to build the business in an intelligent way.

Second, *NovaMed*, based in Chicago, is one of the few companies that have successfully transitioned from a practice management company to a surgery center and facilities management company. Given the bankruptcy of many of the practice management companies from the mid to late 90's, this has not been an insignificant task. They now have ownership in several surgery centers and have made the list of the regular and potential buyers of ASCs. Bill Kennedy and Tom Churillo on the development side have each done a very good of examining transactions and making sure that NovaMed is viewed seriously as a buyer of surgery centers. They have also expanded from simply being an ophthalmology driven company to being owners and operators of multi-specialty centers.

Third, *HealthInventures* is a company operated and run by Dick Hanley. Dick has seen this company evolve from a company owned by himself and a few others to a company that Johnson & Johnson bought and Dick has subsequently repurchased. Dick has been a long time contributor to the surgery center industry, and has done a great job of putting together a team to reenergize this company and provide outstanding services.

Again, these notes regarding Universal, NovaMed and HealthInventures are not intended as endorsements but rather as a source of information.

SURGICAL HOSPITALS

The Medicare Prescription Drug Bill at Section 507 includes specific legislation relative to "specialty hospitals".

1. General Prohibition. The Bill provides an amendment to the "Stark Act" (42 U.S.C. 1395nn). There, it adds a prohibition on the referral by physician owners of Medicare, Medicaid and governmental patients to specialty hospitals. See Section 3 below. The prohibition should arguably not impact the ability of a hospital to become Medicare certified. This point on certification may be challenged by the Center for Medicare and Medicaid Services ("CMS").

2. Exceptions. The legislation provides an exception for each (a) hospitals existing as of November 18, 2003 and (b) hospitals defined as "under development" as of November 18, 2003. Such hospitals must comply with certain limitations. Here, the legislation provides for further limitations as follows. "(a) the number of physician investors at any time on or after such date is no greater than the number of such investors as of such date; (b) the type of categories described in subparagraph (A) cardiac, orthopedic or surgical) at any time on or after such date is no different than the type of such categories as of such date; (c) any increase in the number of beds occurs only in the facilities on the main campus of the hospital and does not exceed 50 percent of the number of beds in the hospital as of November 18, 2003, or five beds, whichever is greater; and (d) that meets such other requirements as the Secretary may specify."

3. Specialty Hospital. The definition of a specialty hospital includes a hospital which is primarily or exclusively engaged in the care and treatment of one of the following categories: (a) patients with a cardiac condition; (b) patients with an orthopedic condition; (c) patients receiving a surgical procedure; and (d) any other specialized category of services that the Secretary designates as inconsistent with the purpose of permitting physician ownership and investment interests in a hospital under this section.

Primarily has traditionally been deemed to mean 50%. Thus, a facility which is more than 50% engaged in treating patients with a cardiac, orthopedic condition or in providing surgical procedures may be considered a specialty hospital. The method of measurement whether by revenues, number of patients treated, number of bills sent out, or otherwise has not yet been determined.

4. Under Development. The legislation defines under development as meaning that (a) architectural plans have been completed, (b) funding has been received, (c) zoning requirements have been met, and (d) necessary state approvals have been obtained. It also includes "any other evidence the Secretary of Health and Human Services would determine whether a hospital is under development as of such date".

5. Studies. The legislation provides for two studies to be conducted. First, MedPac (Medicare Payment Advisory Commission) is to engage in a study as to certain economic issues related to surgical hospitals. Second, the Department of Health and Human Services is to engage in a study that tends to look more closely at referral patterns and whether specialty hospitals involve inappropriate referral patterns. The timeframe for the studies is 15 months.

6. Rural Exception. The Act eliminates the rural exception for specialty hospitals.

7. CMS Regulations, etc. As of this date, CMS is not sure it will have time to issue regulations to define issues raised under the Act. It may issue a program memo or similar issuance to help provide guidance under the Act. CMS does not currently issue advisory opinions relative to the Stark Act. In the absence of guidance, it is possible that individual hospitals will bring action in federal courts to attempt to declare that their facility is not a specialty hospital, that their hospital is currently "under development" or as to certain other issues.

8. Timeframe. The moratorium expires as of May 18, 2005.

Should you have any questions, please call or email Scott Becker at (312) 750-6016 or sbecker@mcguirewoods.com.

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