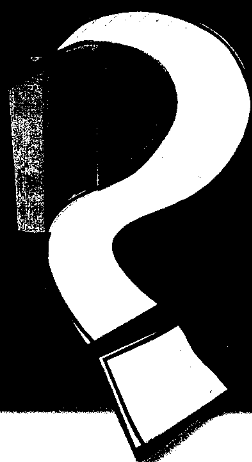


Ask The

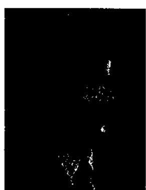
A Question & Answer Editorial On Issues Related To ASCs

***EndoEconomics* invited a panel of legal experts to offer their opinion on issues that are pertinent to the ever changing ASC landscape. In light of the new Medicare reimbursement decision, physicians may be looking for alternative ways to effectively increase their personal revenue either through new center development, hospital joint ventures or acquisitions of their existing facility. Following, are some of the issues presented to our legal correspondents.**

Legal Correspondents:

Scott Becker
McGuireWoods

Sarah E. Abraham
McGuireWoods



William Thompson
Hall, Render, Killian, Heath & Lyman, PSC

Chris Panczner
Epstein Becker & Green, P.C.

Q How do you see the new Medicare conditions of coverage impacting the ASC marketplace?

Becker and Abraham: *We see the changes in the condition of coverage having less impact on ASCs than the impact the changes in Medicare payments will have. With respect to conditions of coverage, these changes will allow a much greater variety of cases to be performed in surgery centers. However, the currently issued conditions of coverage cause some concern as to 23-hour cases which are not specifically important for gastroenterology and endoscopy centers, but are important for more complex cases. The big question is whether this 23-hour limit will apply to commercial cases as well as Medicare cases. Further, as surgery centers have increasing ability to handle the same kinds of cases as hospitals, these changes may also lead to an increased amount of cases performed in offices. In short, as people start to develop their offices into mini surgery centers, they will also have the ability to chip away at the cases performed in surgery centers.*

Thompson: *The changes to the conditions of participation for ASCs are some of the most significant revisions in a long time. Many are administrative in nature, but the definition of "Overnight Stay" and a new rule applicable to patient transfers could make it difficult for ASCs to negotiate an acceptable arrangement with hospitals in their marketplaces. This may add to the tension between hospitals and physician-owned Centers.*

Panczner: *The new Medicare conditions of coverage will require additional administrative efforts for operators of ASCs and a review of the scope of center services. Although not unduly burdensome, the additional required documentation and internal processes will result in additional costs for centers already facing reductions in Medicare reimbursement.*

Q When is the right time to sell equity in your center, and how will a potential increase in the capital gains tax impact these transactions?

Becker and Abraham: *Selling a center is typically driven by the desire to take "cash off the table" or because you need help in managing or turning the center around. In simple terms, there is both a mathematical answer to this question, as well as a personal comfort answer to this question.*

Remember, after you sell a majority interest in the center, for the remainder of your career, you will receive a lesser amount of distributions because you will own a lower percentage of the center after the sale. This is typically the case. Further, when you finally sell the remainder of your interest, you will sell those interests at 3 to 4 times earnings as opposed to the 6 to 8 multiple that you might receive when you sell a majority of the equity in a transaction.

From a mathematical and economic perspective, note the following: If you sell your interest in a surgery center at about 7 times earnings, you typically receive mostly capital gains tax treatment on that sale. This essentially means that if you held the same interest in the center rather than selling such interest, it would take you about 10 to 11 years after taxes to receive the same amount of money for that interest as you would receive in a sale transaction. Then, at the end of 10 to 11 years, you still own the interest in the center.

Given that one cannot forecast the future of a surgery center for this length of time, one might argue that it is always time to consider selling your center if you can receive 6, 7, or 8 times earnings for the center. With that stated, when you reinvest the money that you receive from the sale, it is unlikely that you will receive anywhere near the return on investment month to month from other investment opportunities that you would receive from your surgery center investment. Thus, you are gaining a certain

Experts

amount of comfort and financial security by selling a center, but you are giving up current and ongoing cash flow.

If your operational perspective is very long term, there is a strong argument that you should hold on to your equity in the center. The closer you are to retirement, the stronger the incentive to sell the center and to be part of a selling group because that is the only time you will have a chance to receive 6 to 8 times EBITDA.

The only time that you should always consider selling is if you see the center projected to go in a downward direction. However, one of the challenges is that many buyers will also sense the same concern. An increase in the capital gains tax rate would lessen the amount of time it takes to receive the amount of after-tax income from simply holding on to the center. For example, if it takes about 10 to 11 years to get what someone received in a 7 times EBITDA transaction if they just held their equity, then if the capital gains tax rate were to go up significantly, the length of this holding period starts to decrease to closer to the multiple that you have received in a sale transaction.

For example, if you get paid 7 times earnings and the capital gains tax rates are close to ordinary income tax rates, then the hold period to break even with a sale transaction is about 7 years.

Thompson: *Whether and when to sell equity in your center is driven by a number of factors including anticipated capital needs, the need to "refresh" the complement of surgeon-owners, the need for a third party manager/owner, and/or the desire of current owners to "cash out" some or all of their equity in the center. Tax planning is another consideration. Currently, the capital gains tax rate is 15%, but that rate is scheduled to expire in 2010 unless Congress otherwise takes action. The capital gains rate is unlikely to decrease anytime soon. A rate hike is the more likely scenario.*

Panczner: *Ideally, the time to sell an equity interest in a center is when the value of the practice is high and tax rates are low. An increase in the capital gains rate may make it more lucrative to sell an interest before such change occurs, but it is often possible to structure the sale of an equity interest in a way to defer (but not eliminate) the recognition of the tax.*

Q What are the benefits of a "minority" equity acquisition versus the historical "majority" equity model?

Becker and Abraham: *The core benefit of a minority equity acquisition is that it allows the physicians to continue to hold a majority of the interests in the venture, which is good for the longevity of the venture. The core downside to the physicians is that one receives less of pricing in the sale transactions in which a majority interest is being sold (i.e., 6 to 8 times earnings). Thus, there is a disadvantage in pricing when selling a minority equity position versus a majority position. Also, it is the only time you can ever sell for 6 to 8 times interest. A minority investment option does not provide the same amount or liquidity in exit value.*

However, if a group of minority partners (e.g., a minority corporate partner and a group of physicians) collectively sell a majority interest in a center, they may still receive a 6 to 8 multiple with each seller receiving their pro rata share of the purchase price based on interests sold.

Thompson: *The sale of a minority interest in a center allows the existing owners to retain effective governance and management control over the center, while at the same time realizing some of the appreciation in the value of the center. Of course, a minority interest is going to be valued less than a majority interest since the sale of a majority interest commands a "control premium." This control premium could add anywhere from 1 to 3 times EBITDA to the sale price of a center.*

Panczner: *If the physician group desires to remain active in the business (e.g., not retiring), while generally based upon a lower valuation multiple, the sale of a minority interest in a center may be more advantageous. It may provide additional capital to expand the center or cash payments to the physician owners, while allowing the physicians to generally retain a significant level of control over the operation of the center.*

Q Is there an increased interest in ASC management arrangements between physicians and hospitals? If so, what are the benefits and/or risks involved?

Becker and Abraham: *There is muted increased interest in ASC management agreements. These are often driven by the built-in reimbursement advantage that hospitals enjoy. In essence, hospitals have much more cash to play with in order to pay management agreements, and to pay medical director fees in order to retain physicians and prevent them from developing their own centers. At the same time, very negative comments from the government on these types of arrangements have muted the increased interest in the growth of these arrangements. However, the reduced reimbursement for GI centers is also leading more gastroenterologists to be more interested in looking at other options than their own ASCs.*

Thompson: *Yes. Hospitals are beginning to realize the value of having physicians actively engaged in the day-to-day clinical and administrative operations of an ASC, as well as the surgical service line of the hospital itself. Inpatient surgery services are notoriously inefficient and often in need of focused attention. These arrangements are designed to focus the surgeons on improving quality, patient safety, and efficiency—this pays dividends for both the hospital and the doctors.*

Panczner: *We have seen a renewed interest in physician-hospital joint ventures over the past few years. Physician-hospital joint ventures can*

provide an excellent opportunity to improve relations between the parties, enhance the quality of care in the community and allow for a sharing of expertise, risk and capital costs. Such relationships are, however, subject to increased regulatory scrutiny and must be appropriately structured and operated to limit legal risk.

Q What changes have you seen in the physician-hospital joint venture over the past few years that will impact these relationships in the future?

Becker and Abraham: *The largest change that we see in physician-hospital joint ventures relates to physician-hospital relationships as a whole. In essence, we are seeing a greater number of situations in which physicians are being employed by hospitals than we have seen in several years. This lessens the pool of available gastroenterologists for endoscopy ventures or other types of ventures, and gives the hospitals additional control over case flow.*

Thompson: *Over the past few years, hospital-physician joint ventures have been subject to increased scrutiny by a host of regulatory agencies—such joint ventures are now subject to a labyrinth of complex rules, regulations and laws. In the future, I see these types of joint ventures focusing less on the economic return on investment and more on a ROI expressed in terms of quality improvement and the application of sophisticated information technology.*

Panczner: *Recent state laws regulating certain procedures in physician office settings and efforts by hospitals to improve relations with voluntary physicians will continue to be favorable factors for such ventures. Declining government program reimbursement and a heightened prosecutorial environment relating to physician self-referral, physician-hospital relationships and billing issues have been, and will continue to be, factors of concern in physician-hospital outpatient ventures.*

Mr. Becker is co-chairman of McGuireWoods' Health Care Department. He practices exclusively in the health care regulatory and transactional area. He devotes his efforts to surgery center, hospital and health care provider related transactions, joint ventures, securities, contracting and regulatory matters. He provides counsel to hospitals, ambulatory surgery centers, surgical hospitals, pharmaceutical companies, multi and single specialty medical practices, and a wide variety of health care industry entrepreneurs. He provides service on a national basis to privately held and publicly traded companies relating to health care transactional and regulatory matters, including counsel under the Medicare/Medicaid Fraud and Abuse Statute, the Stark Act, and the Internal Revenue Code Sections 501(c)(3) and c(9).

During the past several years, Mr. Becker has devoted a substantial majority of his time and efforts related to ambulatory surgery centers and to hospitals and health systems. His efforts have included structuring ambulatory surgery center joint ventures; providing legal opinions regarding the 501(c)3, fraud and abuse statute, self referral and Stark implications of surgery center business and physician relationships; drafting and implementing private placements and joint ventures of surgical centers; procuring Certificate of Need determinations; reviewing reimbursement related issues; reviewing antitrust issues; negotiating business contracts; drafting and implementing compliance plans; negotiating private equity investments; and providing advice and counsel on a broad range of business and legal issues. He also has worked with magnetic resonance and other imaging facilities, as well as with cardiac catheterization facilities.

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Ms. Abraham is an Associate at McGuire-Woods, LLP. She focuses on corporate services and regulatory matters for health care companies. In this capacity, she has assisted in negotiating operating agreements, private placement memoranda, asset purchase agreements, and medical director agreements; advised clients with respect to Medicare and Medicaid fraud and abuse laws, the Stark Act, HIPAA, corporate practice of medicine, certificate of need, licensure issues, and general health care compliance issues; and represented a variety of health care providers, including ambulatory surgery centers, hospitals, and dialysis facilities.

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Bill Thompson is President and Managing Partner of Hall, Render, Killian, Heath & Lyman, PSC. He concentrates his practice on financial relationships among health care providers, including hospitals, physicians, and health systems. He provides advice and counsel on a national basis regarding mergers and acquisitions, joint ventures, reimbursement issues, and network integration. Bill also counsels clients on a number of state and federal health care regulatory matters, including fraud and abuse, the Stark Law, antitrust, tax-exempt, and compliance issues. He has been named in "The Best Lawyers in America" under the Health Care Section for ten years running. He has become a counselor and confidant of hospital CEOs and physician leaders across the country, frequently speaks on topics dealing with health care issues, and has authored a variety of articles on health law topics.

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Mr. Panczner is a senior member of Epstein Becker & Green, P.C. in the Health Care and Life Sciences Practice in the firm's New York office. He represents health care providers, payors and investors in health care and life science companies in transactions, compliance investigations and with respect to a wide variety of regulatory matters including licensure, health care fraud and abuse, and health information privacy and security. Mr. Panczner serves on the firm's Health Care and Life Sciences Steering Committee, which sets the strategic direction for the approximately 100 health care attorneys across the country, and is a member of the firm's Technology Committee. He has been named a "New York Super Lawyer" for Health Care Attorneys in *New York Super Lawyers, Manhattan Edition*, a special supplement in The *New York Times by Law & Politics*, 2006 and 2007.

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