

## IN FOCUS

### MERGERS & ACQUISITIONS

# Private equity funds seek health care acquisitions

This sector is positioned for growth even in these difficult economic times.

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GIVEN THE CURRENT market conditions and fierce competition among private equity funds for traditional target companies, many private equity funds are choosing to invest in the highly regulated health care services industry, either as part of a diversified portfolio strategy or as a primary investment focus. The Carlyle Group's approximately \$6.3 billion acquisition of nursing home operator Manor Care Inc. helped to make 2007 a record-setting year for health care private equity transactions.

Legal counsel experienced in health care services transactions can help to guide investors through the continually shifting regulatory landscape and address the deal structuring necessary to manage risk and achieve investment objectives.

The health care services industry (which includes hospitals, nursing homes, long-term care facilities, medical groups and clinics, laboratories, health maintenance organizations (HMOs), disease state management companies and ancillary service providers) is positioned for growth even in these difficult economic times, with health care spending accounting for approximately 16% of the U.S. economy and an aging baby boomer population expected to require higher levels of medical care. According to Nathaniel Zilkha at Kohlberg Kravis Roberts & Co., real spending in health care has gone up 5% in the past three recessions, providing a countercyclical investment opportunity. "The Deal's Healthcare Dealmaking Symposium: What's on PE's radar," The Deal.com, March 19, 2008, [www.thedeal.com/dealscape/2008/03/the\\_deals\\_healthcare\\_dealmakin\\_3.php](http://www.thedeal.com/dealscape/2008/03/the_deals_healthcare_dealmakin_3.php).

With the economic effects of health care spending and rising health care fraud and abuse, it is no surprise that the federal government is looking to reduce health care costs. Without such efforts, many predict that the federal Medicare program will exhaust its trust funds by 2019. Robert Pear, "Outlook Remains Bleak for Two Programs," N.Y. Times,

March 26, 2008, at A15. To reduce incentives for overutilization, the federal Centers for Medicare and Medicaid Services (CMS), which administer the Medicare program (providing health care reimbursement for senior citizens) and the Medicaid program (providing monies to state programs for qualified low-income recipients), recently promulgated additional regulations and guidance that affects the operations of health care providers. In the period since July 2007, these regulations and guidance have massed more than 1,000 pages, with additional issuances expected later this year. These new and upcoming regulatory initiatives underline the critical need for integrating sophisticated health care legal counsel into health care investment transactions.

While on its face a simple issue, what a private equity investor can actually purchase must be analyzed carefully. In more than half the states in the United States, there exists some form of a prohibition on the corporate practice of medicine (CPOM), i.e., the practice of medicine or other regulated health care services by a nonlicensed business entity or the employment by a nonlicensed general business entity of physicians or licensed health care providers. For example, California and Texas do not generally allow a general business entity to employ physicians or other licensed health care providers; to hold contracts with HMOs, insurance companies or other third-party payors; or to bill for professional services rendered to patients. In many other states, there is little statutory or case law guidance, and business is conducted in such states in an environment of uncertainty.

In states that prohibit CPOM, the provision of medical professional services often is carried on through professional corporations or similar entities. State law requires that such entities be owned and run by licensed professionals. Generally, these state laws prohibit the ownership of an equity interest by a nonlicensed, general business entity. It is important to note that the CPOM restriction applies to professional services, but generally not to technical services, those provided by a health care facility other than professional services. Examples would include hospital facility services (the charges for a hospital stay and supplies used) or laboratory services (processing of the laboratory test itself, rather than the professional interpretation of the test results).

Recent and proposed changes to the Ethics In Patients Referrals Act—commonly known as the Stark Law, 42 U.S.C. 1395nn—relating to the act's in-office ancillary services exception, supervision

requirements and the purchased diagnostic services rule, may adversely affect arrangements in CPOM restriction states for billing of technical services. The effects of these changes may cause significant decreases in revenue or business-model problems, raising significant diligence questions for private equity investors.

The CPOM prohibition has had the practical effect of limiting the availability of equity capital for professional corporations and has resulted in alternative capital-raising and management strategies, such as the formation of management services organizations (MSOs). An MSO is a general business corporation or limited liability company that provides administrative services to one or more professional corporations through a management services agreement.

An MSO may choose to employ all or certain nonlicensed staff necessary for the operation of the professional corporations (such as accounting, administrative and technical staff), and often the MSO will own or lease the real estate and personal property assets of the medical business. When the MSO outsources all nonlicensed business functions from the professional corporation, the professional corporation often will hold only the employment or independent-contractor relationships with licensed personnel, the malpractice insurance policies, any necessary health care licenses and accreditations, and the payor contracts.

In return for the management services, the MSO charges a management fee and costs to the professional corporation. The more services provided, the higher the fair market value management fee that can be charged by the MSO. In a state where CPOM is prohibited, professional (and sometimes technical) services must be billed by the professional corporation to the payors (Medicare, Medicaid, HMOs and insurance companies), and revenue flows to the professional corporation. From that revenue, a professional corporation pays the MSO for the services provided, leaving a remainder in the professional corporation to pay the compensation of its licensed providers and its other operating expenses.

#### The anti-kickback statute

A fair market value opinion for the management services compensation to be paid by the professional corporation should be obtained to comply with the federal anti-kickback statute, 42 U.S.C. 1320a-7b. The anti-kickback statute (and its state counterparts) generally prohibits payments, in cash or in kind, in

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return for referring or inducing the referral of patients or any good, item, facility or service for which payment may be made by Medicare or Medicaid. The anti-kickback statute is scienter-based, and violations must be proven to be knowing and willful.

The safe harbor for personal services and management contracts under the anti-kickback statute requires compensation not to exceed fair market value, to be fixed in advance for a period of at least one year and not to vary in volume or value based upon referrals made. This management services agreement safe harbor often is used for compensation based on a fixed monthly or annual management fee, a per-click or per-use based management fee or a "percentage of revenue" management fee (many states deem percentage of net income arrangements, as opposed to percentage of revenue, to constitute illegal fee-splitting). While still allowed by some states, "percentage of revenue" arrangements will not be considered to be "fixed in advance" under the Stark Law in certain cases and thus will not qualify for necessary exceptions.

Therefore, lawyers must pay careful attention to the possibility that physician referrals for "designated health services" (those services that require compliance with the Stark Law, including inpatient and outpatient hospital services, laboratory services, radiology and imaging services, durable medical equipment, outpatient prescription drugs and home health services) could invalidate management services agreement compensation that otherwise would be valid under the federal anti-kickback law. Counsel also must analyze state versions of the self-referral and anti-kickback statutes, as well as corporate practice and fee-splitting issues.

Therefore, if a private equity fund wishes to purchase a business including medical clinics in multiple states that prohibit CPOM, the initial inquiry should focus on how the business currently is held and managed. If no MSO is in place, then there may not be any entity that can legally be owned by a private equity investor, as, generally, professional corporations in many states may not be owned by a private equity fund. In such case, formation of an MSO and creation of management services agreement relationships may be a necessary prerequisite to the completion of an acquisition transaction. The private equity fund then would acquire ownership of the MSO and, with such ownership, hold contractual management relationships with each of the professional corporations.

Conversely, in private equity transactions, it is often the case that a general business entity has been conducting a medical services business directly in a state that generally prohibits CPOM. In such an instance, counsel must conduct legal analysis to gauge the true liability exposure of the business to regulatory action, and the transaction must be structured (either through use of an asset-purchase structure or through appropriate indemnification, hold-back, contingent payment and/or escrow provisions) to mitigate the possible effects on the private equity investor of such preclosing business practices.

If the private equity investor is buying a clinic-based business with multiple professional corporations in several states, who will own the professional corporations? Since a private equity fund would not be properly licensed, it must locate one or more properly licensed and qualified, supportive and friendly

physicians or health care providers to own the professional corporations that hold the payor contracts and the employment or contractual relationships with the health care professionals. In industry convention, a physician holding such ownership is referred to as a "Dr. Friendly," and usually has contractual restrictions put in place on his or her equity holdings, such as a buy-sell arrangement with a pre-set valuation or valuation approach, or provisions relating to the choice of successor owners and restrictions on operational activities, such as dividends and distributions, management, contracting and other monetary or liability-sensitive areas.

## Ban on corporate practice of medicine is a major hurdle.

While in many businesses the simplest approach is to use an asset-purchase structure and just have the seller retain all preclosing liabilities, this is not always possible in health care services deals if the parties do not wish to interrupt post-closing operational cash flow. The entity holding the contracts with the payors and the relevant provider agreements/numbers from Medicare and Medicaid is subject to an accreditation and contracting process, and a new entity formed to make such purchase will lack such accreditations and provider agreements/numbers. Assuming such can be obtained, the process often can take months to complete, during which time billing for services rendered cannot occur. In some instances, counsel can successfully implement an interim structure whereby the seller allows the buyer to use its existing licenses, provider numbers and accreditations.

Most payor contracts require consent to assignment, even in the event of a stock purchase or merger structure. Payor consents often can take months to negotiate, as many payors use change-in-control transactions to renegotiate more favorable contract terms. In recent years, payors also have been attempting to implement during change-in-control transactions new contract forms with more payor-friendly terms and conditions.

Buyers that use a stock-purchase/merger structure, or that use an asset-purchase structure and accept assignment of the Medicare-provider agreement, would step into the shoes of the entity and be liable for preclosing acts of the purchased entity. As such, they would bear primary responsibility vis-à-vis the payor for overpayment liabilities, billing problems and false claims. While counsel can allocate this risk to some extent through appropriate indemnification and contribution provisions, as well as escrow, hold-back and purchase price adjustment provisions, they may not be able to address certain eventualities in this manner. Such eventualities include recoupment actions for large amounts of prior claims, actions by Medicare to exclude the health care entity from the Medicare program due to its prior acts (the economic effect of which may render the business no longer viable) or civil liability under the federal False Claims Act, 31 U.S.C. 3729, et seq.

It is highly recommended that counsel review the target company's billing and collections policies and procedures; its history of denied and contested claims, repayments and recoupments; and its correspondence with third-party payors and fiscal intermediaries (in-

urance companies that contract with Medicare to process claims). It also is suggested that a qualified independent consultant conduct a billing audit, which would focus on a test sample of billing claims over a period of time, to assess compliance with Medicare and fiscal intermediary rules and policies. Problems may be addressed through transaction structure, repayment, indemnification or other contractual remedies, or self-disclosure to the payor.

First enacted in 1989 to combat perceived overutilization of imaging centers owned by physicians, the Stark Law encompasses a number of statutes (Stark I and Stark II) and regulations, along with the Phase III regulations for Stark II issued in 2007 and additional guidance and proposed amendments issued in 2008. The Stark Law prohibits a physician from making a referral to an entity for the provision of "designated health services" reimbursable by Medicare, if the physician or a family member has a direct or indirect financial relationship with such entity. Further, the entity receiving the "tainted" referral may not bill Medicare for such services. While the Stark Law is not a criminal law, it is a "strict liability" law, and there is no need to prove intent to violate the law (as is the case with the anti-kickback law). The exceptions or safe harbors require strict compliance, as failure to meet such requirements results in a violation of the law (unlike the anti-kickback law, in which the safe harbors are voluntary and nonexclusive).

For private-equity investors interested in purchasing a hospital, the recent Stark Law's actual and proposed changes adversely affect the ability of such investors to partner with local physicians. Hospital services previously could be outsourced to an entity with physician owners (such as for diagnostic imaging, dialysis, ambulatory surgery or radiation therapy). The hospital would pay the outsourcing entity for services and would bill payors for outsourced services performed. This "underarrangements" model will no longer be allowed once pending regulations are finalized by CMS. CMS has been concerned about contractual joint ventures for years (as discussed in Staff Advisory Bulletin, 68 Fed. Reg. 23148, April 30, 2003). Additionally, physician ownership of hospitals has come under challenge in recent proposed legislation to amend the Stark Law. Further, the "stand in the shoes" analytic concepts recently adopted for physician relationships, 42 C.F.R. 411.354(c)(2)(iv), and now proposed to be applied to hospitals and other facilities, have the effect of tightening up compliance requirements under the Stark Law and potentially prohibiting a number of previously used forms of relationships between hospitals and physician-owned entities.

Given the recently enacted and proposed changes in the law and interpretive guidance from CMS, experienced legal counsel can help private-equity investors successfully structure a private equity acquisition and determine if targeted financial objectives and cash flows can be achieved within the permissible scope of current and anticipated health care regulation. **NLJ**