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CHAPTER 5

EQUITY TRANSACTIONS IN THE AMBULATORY SURGICAL CENTER INDUSTRY

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§ 5.01 INTRODUCTION

In today's market, there are a myriad of equity transactions taking place in the ambulatory surgical center (ASC) industry. These transactions typically fall into one of three categories. The first is the sale of ownership interests in an ASC to physicians who use or will be using the ASC. These transactions can involve the initial syndication of equity interests to physicians in a new ASC or the sale of equity interests to physicians in an existing ASC. Second is the redemption (i.e., buy-back) of a physician's equity interest in an ASC. Third is the sale of an equity interest to a corporate investor (e.g., ASC management companies and health systems).

Buying and selling interests in an ASC, however, raises a litany of business and regulatory issues. Before considering the development of an ASC or the sale or purchase of an equity interest in an ASC, it is essential to understand the best practices in structuring these transactions and the critical regulatory compliance issues. This chapter addresses the business and regulatory compliance issues in the development, sale, and acquisition of an ASC. This chapter is divided into five sections.

- The first section provides a primer on the two primary federal health care laws: 42 U.S.C. § 1320a-7b(b)(1) *et seq.* and the regulations promulgated thereunder (the anti-kickback statute) and 42 U.S.C. § 1395nn *et seq.* and the regulations promulgated thereunder (the Stark law).
- The second section provides a detailed discussion of the business and regulatory issues arising in the sale of equity to utilizing physicians in connection with the development of new ASCs and the sale of equity in existing ASCs. In particular, this section addresses the best practices for developing a corporate structure from which to operate an ASC, the initial syndication of equity interests to physician owners, whether through a private offering or otherwise, as well as both the business and regulatory advantages and disadvantages of group practice ownership of an ASC.
- The third section addresses the redemption or buy-back of equity interests from physician owners of an ASC, which typically occurs when a physician is no longer practicing (e.g., upon death, disability, relocation, etc.). These concepts are contained in the governing document of the ASC. This section also highlights the importance of a solid governing document and the other key concepts that should be addressed therein, as well as the business and regulatory issues that arise in dealing with non-productive physicians.
- The fourth section discusses key issues that arise in selling an equity stake to an ASC management company, hospital, or health system or other corporate investor.
- The fifth section addresses certain key issues in connection with due diligence in an ASC transaction. This section further addresses the issues related to a change of ownership of an ASC from a Medicare, certificate of need (CON), and state licensure perspective.

§ 5.02 CERTAIN APPLICABLE HEALTH CARE LAWS

[A] Federal Anti-Kickback Statute

[1] General Prohibition

The anti-kickback statute prohibits an ASC, its physician owners, or any other person or entity from knowingly giving or getting anything of value in exchange for referrals or orders for items or services that may be covered by a federal health care program.¹ Violation of the anti-kickback statute is a felony, punishable by imprisonment of up to five years, fines of up to \$25,000, or both.² If a provider is convicted of a violation of the anti-kickback statute, the provider is subject to the equivalent of the “death penalty” in the health care industry—mandatory exclusion from participation in Medicare and other federal health care programs.³

A violation of the anti-kickback statute can also result in civil and administrative penalties, regardless of any criminal liability. Under the civil monetary penalties provision of the Social Security Act, committing an act proscribed by the anti-kickback statute can result in exclusion from participation in federal health care programs and administratively imposed civil monetary penalties of up to \$50,000 per kickback and three times the amount of the illegal remuneration received.⁴

The government is also continuing to use the federal False Claims Act as an enforcement tool against alleged anti-kickback statute and Stark law violations.⁵ Because the penalties in False Claims Act cases include the recovery of treble damages for each false claim, the amount at stake for a provider can become quite substantial. Moreover, the False Claims Act allows for a private citizen to bring a *qui tam* (or whistleblower) action and share in the recovery, thereby increasing the frequency of these cases being brought to the government’s attention.⁶

[2] Safe Harbors

The broad scope of the anti-kickback statute and the uncertainties that it created for the health care industry led Congress to enact § 14 of the Medicare and Medicaid Patient and Program Protection Act of 1987.⁷ This provision requires the U.S. Department of Health & Human Services (HHS) to promulgate “safe harbor” regulations. The safe harbor regulations specify those financial arrangements that will not be subject to criminal prosecution or civil liability under the anti-kickback statute.

One such safe harbor directly addresses investments in an ASC. Other relevant safe harbors impact certain financial arrangements into which an ASC may enter in the normal course of business. All of the safe harbors are very

¹ 42 U.S.C. § 1320a-7b(b)(1) *et seq.*

² 42 U.S.C. § 1320a-7b(b).

³ 42 U.S.C. § 1320a-7(a)(1).

⁴ 42 U.S.C. § 1320a-7a.

⁵ 31 U.S.C. §§ 3729–3733 (2006).

⁶ *See, e.g., United States v. Rogan*, 2006 WL 2860972 (N.D. Ill. Sept. 2006).

⁷ Pub. L. No. 100-93.

narrow and apply only to financial arrangements that strictly comply with each element of the applicable safe harbor.

[a] The ASC Safe Harbor

The ASC safe harbor is divided into the following four categories: (1) surgeon-owned ASCs, (2) single-specialty ASCs, (3) multi-specialty ASCs, and (4) hospital/physician owned ASCs.⁸

[i] *What Do All Four Categories Have in Common*

All four categories of the ASC safe harbor have the following key criteria in common: (1) each physician investor must disclose to the patient that such physician has an ownership interest in the ASC; (2) the investment terms must be unrelated to referrals or other business generated by the referring physician; (3) 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 investor's performance of ASC procedures (the "one-third income test"); (4) neither the ASC nor any other investor can loan monies to another investor to acquire an interest in the ASC; and (5) the return on investment paid must be proportional to the amount of capital invested. Under the safe harbor regulations, a "procedure" is defined as "any procedure or procedures on the list of Medicare-covered procedures for ambulatory surgical centers[.]"⁹

The patient disclosure requirement addresses the potential for a conflict of interest that arises when a physician investor refers a patient for a "procedure." To avoid the potential for an undisclosed conflict, and particularly given the relative ease by which this standard can be met, most ASCs should consider satisfying this standard even if the ASC does not otherwise satisfy all of the other elements of the safe harbor. As discussed in more detail below, failing to satisfy all of the elements of a safe harbor does not necessarily mean the arrangement is in violation of the anti-kickback statute. Accordingly, it is quite common for ASCs to try to satisfy as many of the elements of the applicable safe harbor as possible. Figure 5-1 provides an example of a physician investor disclosure form.

Figure 5-1: Physician/Patient Disclosure Form

During the course of your physician/patient relationship with the physician, the physician may at a future time refer you to ABC Surgery Center, which operates an ambulatory surgery center located at 123 Surgery Street, City, State 99999.

In connection with any such referral, the physician hereby advises you that the physician has an investment interest in ABC Surgery Center LLC, and thus in its ambulatory surgery center.

(continues)

⁸ 42 C.F.R. § 1001.952(r).

⁹ 42 C.F.R. § 1001.952(r)(5).

Figure 5-1 (*continued*)

Please be advised that you have the right to obtain the health care items and services for which the physician refers you at any location or from any ambulatory surgery center, hospital, provider, or supplier of your choice, including ABC Surgery Center LLC.

I, the undersigned patient, received this Physician/Patient Disclosure Form from the above-referenced physician, and I read and understood the information contained in this Physician/Patient Disclosure Form. The physician furnished me with this Physician/Patient Disclosure Form prior to the physician[92]s referral of me to ABC Surgery Center LLC. The physician further provided me with a list of other facilities at which I could receive the services and discussed these options with me.

Date: _____ 200__

(Signature of Patient)

(Printed Name of Patient)

(Home Street Address of Patient)

(City, State, Zip of Patient)

(Telephone Number of Patient)

With respect to the loaning of money, the ASC safe harbor requires that no funds be loaned by the ASC or an investor to another investor. There are occasions where a potential physician investor does not have or does not desire to commit the financial resources to acquire his or her interest in the ASC. In such instances, an often successful strategy is for the ASC or its founding owners to facilitate a loan to the potential owner through ties they may have with a local lender or other third party who is not an investor in the ASC.

The ASC safe harbor also requires that the investment terms must not be related to the previous or expected volume of referrals, services furnished, or the amount of business otherwise generated from that investor or entity. This requirement highlights the Office of Inspector General’s (OIG’s) concern that an ASC may otherwise attempt to disguise improper kickbacks or referral payments as legitimate investment income.¹⁰ In practice, this means that an ASC cannot

¹⁰ See 64 Fed. Reg. 63,518, 63,536 (Nov. 19, 1999) (HHS explains that in the ASC context, its “chief concern is that a return on an investment in an ASC might be a disguised payment for referrals.”)

provide a physician investor with unreasonably favorable terms, or it could be construed as remuneration to induce the physician to make referrals to the ASC.

For this reason, it is important to keep the key transaction terms, such as price, amount of equity offered, and other terms, consistent among physician investors, unless there is a valid reason for setting different terms that has nothing to do with the volume of referrals. Examples of valid reasons for differential terms may include physician seniority (particularly in connection with ASCs owned by group practices), the timing of the sale (e.g., prior to receipt of CON approval, after commencement of the ASC's construction, before versus after a private offering, etc.), and the amount of risk being assumed.¹¹

As mentioned above, physician ownership in ASCs cannot be based on previous or anticipated utilization. As a result, the ownership of many existing ASCs has no correlation with the actual utilization by the physician owners. Physicians in many of these ASCs, however, want to reallocate the ownership in a manner that more closely reflects ASC utilization. Beware that taking such actions could have the same anti-kickback statute implications described above with respect to offering new potential physician investors an opportunity to purchase an interest in the ASC on more favorable terms.

Another requirement common to each category of the ASC safe harbor is the one-third income test. The one-third income test stems from the rationale that an ASC should essentially be an extension of the physician's or surgeon's existing practice.¹² Thus, the one-third income test is intended to ensure that passive physicians do not own ASCs and receive remuneration merely for referrals to the ASC.

[ii] *Multispecialty ASCs and the One-Third Procedures Test*

For a physician investing in a multispecialty ASC, at least one-third of the procedures performed by a physician for the previous fiscal year or previous 12-month period must be performed at the ASC in which such physician is an investor (the "one-third procedures test").¹³ If the ASC is a start-up, then such requirement will apply upon the completion of the initial 12 months of the ASC's operations.

The one-third procedures test is intended to provide further assurance that the physician or surgeon investing in a multi-specialty ASC is not in a position to refer across specialties without being a real utilizer of that ASC. As HHS indicated in promulgating this requirement, "[w]e believe that for physicians who meet the 'one-third/one-third' test, an investment in an ASC truly qualifies as an extension

¹¹ See also Jerry J. Sokol, Esq. and Joshua M. Kaye, *Physician Ownership and Governing Documents; Avoiding Disputes Among Physician Users of ASCs*, Administrative Eyecare, Vol. 14, No. 2 (Spring 2005).

¹² See, e.g., 64 Fed. Reg. at 63,535-36 (Nov. 19, 1999).

¹³ 42 C.F.R. § 1001.952(r)(3)(iii).

of the physician's office."¹⁴ According to HHS, "such investors are unlikely to have significant incentives to generate referrals for other investors because of the minimal additional return on investment derived from such referrals."¹⁵

[iii] Additional Safe Harbor Requirement When a Hospital Is an Investor

There are two additional requirements when a hospital is one of the investors in an ASC. The first requirement is that any arrangement under which space, equipment, or services are provided to the ASC by the hospital must comply with the appropriate safe harbor for that type of transaction.¹⁶ The applicable safe harbors for such arrangements are discussed in more detail below. The second requirement is that "[t]he hospital may not be in a position to make or influence referrals directly or indirectly to any investor or the entity."¹⁷ From a practical perspective, this latter requirement is somewhat unrealistic for many hospital/physician ASC joint ventures, since hospital/physician arrangements often involve hospitals that employ primary care physicians who refer to the surgeons who use the ASC. Clearly, an employer is in a position to "make or influence referrals." Accordingly, it is rare for such hospital/physician-owned ASCs to qualify for safe harbor protection. As discussed in § 5.02[A][3][b][iii], however, the hospital can incorporate certain contractual and operational safeguards to minimize the likelihood of any government scrutiny under the anti-kickback statute.

[b] Safe Harbors for Space, Equipment, Personal Services, and Management Contracts

The space rental, equipment rental, and personal services and management contracts safe harbors are substantially similar, differing only in the subject of the transaction and related nuances. All three of these safe harbors require the following: (1) the parties must enter into a written agreement, (2) the term of the agreement must be for at least one year, and (3) the agreement must cover all of the respective space, equipment, or services between the parties.¹⁸ Where the space, equipment, or services are not used, occupied, or provided, respectively, on a full-time basis, the agreements must specify "exactly the schedule of such intervals, their precise length, and the exact charge for such intervals" on an aggregate basis.¹⁹

All three safe harbors further require that the compensation paid pursuant to these arrangements be set in advance, consistent with fair market value in arms-length transactions and "not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the

¹⁴ 64 Fed. Reg. at 63,518, 63,535 (Nov. 19, 1999).

¹⁵ *Id.*

¹⁶ 42 C.F.R. § 1001.952(r)(4)(v).

¹⁷ 42 C.F.R. § 1001.952(r)(4)(viii).

¹⁸ 42 C.F.R. § 1001.952(b)-(d).

¹⁹ *Id.*

parties[.]”²⁰ Finally, each of these safe harbors requires that the arrangement be for a commercially reasonable purpose.²¹

As mentioned above, each of the space, equipment, and services safe harbors requires that the aggregate compensation be set in advance. This means that the total amount of compensation to be paid over the term of the arrangement must be set prior to commencement of the arrangement. A per click, per procedure, or percentage-based compensation arrangement would not qualify the arrangement for safe harbor protection even where the per click or other variable compensation amount per unit is set in advance because the aggregate compensation would vary depending on the number of procedures or the amount of revenue. Importantly, this is one of a handful of material differences between the anti-kickback statute and the Stark law. Unlike the anti-kickback statute, the Stark law permits arrangements to qualify for the applicable Stark law exception as long as the per unit amount is set in advance even though the aggregate amount of compensation is not.

From a practical perspective, the “set in advance” requirement makes safe harbor protection very difficult to achieve and creates a tension between the parties’ legitimate business purposes and the desire to obtain safe harbor protection. From a business perspective, a party often desires an agreement for a significant duration—perhaps a three-year, five-year, or longer term. The parties, however, often will desire for the financial terms underlying the arrangement to be reviewed and perhaps increased or decreased during each year of the term based upon the events that transpired during the previous year of the term. While doing so likely would further promote the respective parties’ business interests, any change in compensation would take the arrangement out of safe harbor compliance. As a result, a party often must decide to either (1) promote its business interests of having the security of a longer-term agreement subject to certain price adjustments at the risk of being out of safe harbor compliance; or (2) attempt to qualify for safe harbor protection by having an agreement subject to a shorter term without a fixed price structure for the entire term at the risk of the agreement terminating or expiring after a shorter duration.

The “commercially reasonable business purpose” test means that “the purpose [of entering into the agreement] must be reasonably calculated to further the business of the lessee or purchaser.”²² As HHS has explained, the entity contracting for the space, equipment, or services must need, intend to utilize, and actually utilize the same “in furtherance of its commercially reasonable business objectives.”²³ The “commercially reasonable business purpose” test is aimed at

²⁰ *Id.*

²¹ *Id.* The personal services and management contracts safe harbor also requires that “services performed under the agreement do not involve the counseling or promotion of a business arrangement or other activity that

violates any State or Federal law.” 42 C.F.R. § 1001.952(d)(6).

²² 64 Fed. Reg. 63,518, 63,536 (Nov. 19, 1999); *see also* 42 C.F.R. § 1001.952(d)(7).

²³ *Id.*

ensuring that parties do not utilize “sham” arrangements that are technically compliant with the safe harbors but are in fact merely disguised kickbacks.²⁴

While often overlooked, the “commercial reasonableness” test can implicate certain contractual arrangements that, on their face, appear to qualify for safe harbor protection. For example, suppose an anesthesia group and an ASC enter into a lease pursuant to which the anesthesia group leases a substantial amount of space in an ASC in exchange for a fair market value payment that is fixed in advance for a term of at least one year. While the arrangement appears to meet the space safe harbor, the parties must be mindful that it also satisfies the commercial reasonableness test. If the anesthesia group is leasing substantially more space than it otherwise requires, a regulator could potentially question the commercial reasonableness of such an arrangement. This is just one of many examples where the commercial reasonableness test could be implicated with respect to an arrangement that otherwise on its face meets all of the other criteria of the applicable safe harbor.

[3] Navigating the Anti-Kickback Statute Outside the Safe Harbors

[a] Case Law

To the extent an arrangement qualifies for safe harbor protection, the parties should be immune from any anti-kickback statute liability.²⁵ Thus, the safe harbors provide optimal regulatory comfort.²⁶ While it is advisable to structure a financial arrangement within the confines of a safe harbor when possible, the tension between the stringency of the safe harbors and business realities in the ASC industry regularly keeps compliance with all elements of the applicable safe harbors out of reach.

Importantly, financial arrangements that do not satisfy every element of a safe harbor do not necessarily violate the anti-kickback statute nor subject the participants to prosecution. This is another example of how the anti-kickback statute and the Stark law differ. The Stark law is a strict liability statute, meaning that an arrangement must qualify with all elements of an exception in order to be in compliance with the Stark law. By contrast, a financial arrangement that does not qualify for safe harbor protection will be subject to the same analysis under the anti-kickback statute that would have applied before the safe harbors were promulgated. In other words, safe harbors are intended to afford immunity, but

²⁴ *See id.*

²⁵ It is worth noting that the OIG has promulgated a profit opportunity theory pursuant to which the OIG has suggested that the profit opportunity provided to a physician could be construed as illegal remuneration even where all of the financial relationships

otherwise qualify for safe harbor protection. *See OIG Special Advisory Bulletin: Contractual Joint Ventures* (Apr. 2003).

²⁶ Actually, an entity that has no financial relationships with its referring physicians provides optimal regulatory comfort.

failure to satisfy a safe harbor does not, standing alone, constitute a violation of the anti-kickback statute.²⁷

Financial arrangements falling outside the anti-kickback statute safe harbors will be analyzed to determine whether at least one purpose of the arrangement is an improper inducement or solicitation of referrals. One could easily (but perhaps erroneously) conclude that as long as the arrangement involves fair market value remuneration, whether as a return on investment or compensation, then it would be difficult for a regulator to prove that the arrangement is for an improper inducement or solicitation of referrals.

Such conclusion, however, is not always the case. Multiple courts have held that even fair market value transactions could involve illegal remuneration.²⁸ For example, in *United States v. Greber*, the court determined that the payment of a fair market value consulting fee to a physician who referred patients for Holter monitoring constituted illegal remuneration because one purpose of the fee was to induce the physician to order the Holter monitoring service.²⁹

Notwithstanding *Greber* and similar decisions, at least one appellate court has recognized that the mere hope for, or expectation of, referrals collateral to a legitimate motive for the financial arrangement does not rise to the level of an improper purpose.³⁰ Following the court's reasoning in *Hanlester Network v. Shalala*, an improper inducement must be more than mere encouragement to make referrals or more than an economic incentive to make referrals derived from an investment made on commercially reasonable terms unrelated to the volume or value of historical or anticipated referrals.³¹ While the *Hanlester* case is often cited by health care attorneys and experts, an ASC will want to carefully analyze the transaction under *Hanlester* before engaging in such arrangement. First, it is only binding law in those states comprising the 9th Circuit of the United States Courts of Appeal.³² Second, the OIG may not necessarily agree with the rationale of that decision.³³

²⁷ See, e.g., 64 Fed. Reg. 63,518, 63,536 (Nov. 19, 1999) (In promulgating the ASC safe harbor, HHS recognized that "some legitimate ASC arrangements may not fit precisely in the final ASC safe harbor.")

²⁸ See, e.g., *United States v. Bay State Ambulance and Hosp. Rental Serv.*, 874 F.2d 20 (1st Cir. 1989) (rejecting the defendant's argument that the jury had to find that the payments were not consistent with fair market value and stating that "[g]iving a person an opportunity to earn money may well be an inducement to that person to channel potential Medicare payments ..."); *United States v. Hancock*, 604 F.2d 999, 1001-02 (7th Cir. 1979), *cert. denied*,

444 U.S. 991 (1979) (rejecting the notion that fees for legitimate services could not be illegal kickbacks).

²⁹ See *United States v. Greber*, 760 F.2d 68, 71 (3d Cir.), *cert. denied*, 474 U.S. 988 (1985).

³⁰ See *Hanlester Network v. Shalala*, 51 F.3d 1390 (9th Cir. 1995).

³¹ See *id.*; see also *United States v. LaHue*, 2001 U.S. App. LEXIS 13495 (10th Cir. 2001).

³² The 9th Circuit is comprised of Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, and Washington.

³³ Cf. *United States v. Starks*, 157 F.3d 833 (11th Cir. 1998); *United States v. Davis*, 132 F.3d 1092 (5th Cir. 1998).

Assuming the government proves that an arrangement involves an improper inducement, the anti-kickback statute arguably also requires the government to prove that the parties knowingly entered into a transaction that was unlawful. Multiple federal appellate courts have interpreted the “knowing and willful” language to require proof that the accused party offered, paid, solicited, or received the remuneration with the knowledge that his or her conduct was unlawful.³⁴ Accordingly, a violation of the anti-kickback statute likely requires proof that (1) one purpose of the transaction was to induce referrals for a service or item covered by a federal health care program (or to induce a person to order, purchase, lease, or arrange for, or to recommend the order, purchase, or lease of, a service or item covered by a federal health care program); and (2) the parties knew that the transaction was unlawful. Notwithstanding the above, an ASC or other investors should be certain to consult with legal counsel experienced in these matters prior to engaging in any such arrangement or upon becoming aware of or otherwise involved in an investigation.

[b] Advisory Opinions and Other Compliance Guidance

[i] *Approximating Safe Harbor Compliance*

Financial arrangements not fitting squarely within a safe harbor can still be structured to minimize regulatory risk. The first step is usually structuring the transaction to incorporate as many elements of the relevant safe harbor(s) as possible. By doing so, an arrangement can at least approximate compliance with the safe harbor, thereby arguably decreasing the regulatory risk associated with such an arrangement.

[ii] *Advisory Opinions*

For deal-specific guidance, an ASC may request an OIG advisory opinion.³⁵ Congress established the OIG advisory opinion process to provide further comfort that certain legitimate arrangements that fall outside a safe harbor would not result in OIG enforcement activities.³⁶ An OIG advisory opinion is a legal opinion issued by the OIG to one or more requesting parties regarding the application of the OIG’s fraud and abuse authorities to a business arrangement. Once issued, the advisory opinion is legally binding on HHS and on the requesting party or parties but is not binding on any other governmental department or agency, including the Centers for Medicare & Medicaid Services (CMS). A party that receives a favorable opinion is protected from OIG enforcement, as long as the arrangement at issue is conducted in accordance with the facts submitted to the OIG. The arrangement, however, still must be structured to comply with other applicable laws, including the Stark law.

³⁴ See *id.*

³⁵ 42 U.S.C. § 1320a-7d(b) (2006).

³⁶ See 42 U.S.C. § 1320-7d(b).

Any individual or entity may submit a request for an advisory opinion. To do so, the arrangement must, at the time of the request, either be in existence or be an arrangement into which the parties have a good faith intention to enter in the future, the latter often being the more likely scenario. The party requesting the advisory opinion must be involved directly in the arrangement. Additionally, only certain issues are properly addressed in the advisory opinion.

These include:

- What constitutes prohibited remuneration;
- Whether an arrangement or proposed arrangement satisfies the criteria set forth in the statute or regulations for activities that do not result in prohibited remuneration; and
- Whether any activity or proposed activity constitutes grounds for the imposition of a sanction.

Matters that are inappropriate advisory opinion requests include hypothetical situations, model arrangements, general questions of interpretation, evaluation of the fair market value of goods, services, or property, and the application of other statutes, including the Stark law, which has its own advisory opinion process.

There are a number of reasons to request an advisory opinion. Parties to an arrangement may want to request one when the risk of proceeding without the OIG's approval may be too great; when there is a strong likelihood of a favorable opinion and when the benefit of a favorable opinion would be worth the time and expense involved in making the request; or when there are other compelling business justifications. For example, if a potential transaction has a high degree of regulatory uncertainty, it may be difficult to attract physicians, secure financing, obtain new capital investment, or sell the ASC without first obtaining a favorable advisory opinion. It also is not unheard of for a party to consider obtaining an advisory opinion in connection with an arrangement that it does not want to enter but for business reasons does not want to be the one who "killed" the deal. In such instances, a party may attempt to obtain an advisory opinion, knowing that a negative opinion will likely be issued in order to have a regulatory justification to not enter into the transaction or enter into another deal with better terms.

It is important to note that even where there is regulatory uncertainty surrounding an arrangement, advisory opinions are voluntary. A party's failure to seek an advisory opinion about a transaction or business arrangement may not be introduced into evidence to prove that the party intended to violate the law. Additionally, the requesting party may withdraw its request at any time before the opinion is issued.

There are a number of reasons to not request an advisory opinion. First and foremost, if an arrangement is questionable, it is unlikely that the parties will receive a favorable advisory opinion. Second, there is a fair amount of legal and other related expense associated with the process. Third, to request an advisory opinion, a party must present all facts relevant to the subject matter for which the opinion is being requested. Since advisory opinions are only applicable for the

exact situation disclosed to the OIG, any late changes decrease the opinion's utility. Fourth, all parties and potential parties to the arrangement must be identified in the request. Fifth, and an often-cited reason for not obtaining an advisory opinion, is that it may be impractical for the parties to wait the time that it takes to receive the opinion. The law provides that an advisory opinion should be issued within 60 days from submission of a completed application.³⁷ In practice, however, many requestors' actual experience is inconsistent with the statutory timeframe, and it generally takes anywhere from nine months to three years before an advisory opinion is issued.

[iii] Specific Relevant Advisory Opinions

Only the parties to an advisory opinion can rely on such an opinion as a defense to any prosecution under the anti-kickback statute. That does not prevent others from using previously issued advisory opinions to better understand the government's perspective and incorporate the government's guidance in establishing the transaction terms. Indeed, advisory opinions can set benchmarks and criteria by which to evaluate certain issues.³⁸ In that regard, below is a discussion of two recent advisory opinions relevant to investments in an ASC.

On January 21, 2003, the OIG posted Advisory Opinion 03-02.³⁹ The importance of this opinion is that it identifies certain safeguards that a hospital should incorporate into any hospital/physician ASC joint venture. In particular, the OIG addressed a medical center's proposed acquisition of an ownership interest in an established single-specialty ambulatory surgery center that was owned by an orthopedic group. The OIG concluded that, while the arrangement posed risk of generating prohibited remuneration under the anti-kickback statute, there were sufficient safeguards within the arrangement such that the OIG would not impose administrative sanctions on the requestors if they entered into the arrangement. Specifically, the OIG noted that the arrangement had multiple elements that made it particularly susceptible to fraud and abuse.

One primary concern—the medical center was in a “position to make or influence referrals to the [group practice, the group's shareholders, and the ASC] by using its control and influence over” physicians employed by or otherwise affiliated with the medical staff of the medical center.⁴⁰ The OIG was satisfied, however, that this risk was minimized since the medical center certified it would implement the following safeguards:

³⁷ The HHS regulations implementing the OIG advisory opinion process are found at 42 C.F.R. Part 1008 (implemented via 63 Fed. Reg. 38,311 (1998) (revised final rule)). See 42 C.F.R. § 1008.43(c).

³⁸ See *Official Says OIG Uses Advisory Opinions to Provide Guidance, Promote Compliance*, *BNA's Health Care Daily Report*, Vol. 12, No. 83

(May 1, 2007), addressing speech by Vicki Robinson, OIG Industry Guidance Branch Chief given at the Health Care Compliance Association 2007 Compliance Institute on Apr. 23, 2007.

³⁹ See *OIG Advisory Opinion 03-02* (Jan. 21, 2003).

⁴⁰ *Id.*

1. The medical center will refrain from taking any actions to require or encourage employed and other affiliated physicians to refer patients to the ASC, the group practice, or its shareholders.

2. The medical center will not track referrals made by employed or other affiliated physicians to the ASC, the group practice, or its shareholders.

3. Compensation paid to the medical center employed and affiliated physicians will not be related, directly or indirectly, to the volume or value of referrals or other business generated by such physicians to or for the ASC, the group practice, or the group's shareholders. Such compensation will be consistent with fair market value in arm's-length transactions.

4. Hospital-employed physicians would not make referrals directly to the ASC although they may refer patients to the group practice or the group's shareholders.

5. The hospital would notify the affiliated physicians of these measures on an annual basis.

To the extent a hospital or health system is involved in an ASC transaction or is otherwise contemplating doing so, it may be unable to structure the arrangement to comply with all of the elements of the hospital/physician ASC safe harbor. In such instances, it should be certain to incorporate the above safeguards. By doing so, it should reduce the likelihood of any scrutiny under the anti-kickback statute.

On February 13, 2003, the OIG posted Advisory Opinion 03-05, in which the OIG addressed a proposed ASC joint venture between a hospital (49 percent ownership) and a multi-specialty group practice (51 percent ownership).⁴¹ The importance of this opinion is that it draws into question the ability of an ASC to be owned by a group practice comprised of surgeons and nonsurgeons.

In particular, the OIG indicated that the joint venture posed more than a minimal risk of fraud and abuse because it would not fit into any categories of the ASC safe harbor. The ASC safe harbor applies only to physician-investors who use the ASC regularly as an extension of their practice. In the instant case, only a handful of the physicians in the group would be active users of the ASC. Cross referrals for services performed in the ASC were likely. In all, the OIG equated the arrangement's risk with that of an ASC owned directly by both surgeons and primary care physicians or other physicians who do not utilize the ASC. The OIG stated that the "[p]roposed [a]rrangement poses the same risks as an ASC owned directly by surgeons and primary care physicians in the same community."⁴²

The OIG reached its conclusion based on a very brief analysis. Interestingly, it did not even consider the group practice safe harbor to the anti-kickback statute, which could potentially be utilized for certain group practice-owned ASCs.⁴³

⁴¹ See *OIG Advisory Opinion* 03-05 (Feb. 13, 2003).

⁴² *Id.*

⁴³ See 42 C.F.R. § 1001.952(p).

Prior to the issuance of 03-05, most health care legal advisors conceded that direct ownership by primary care physicians or nonutilizing physicians in an ASC would pose a significant regulatory risk. Most health care experts, however, historically believed indirect ownership by such physicians in a group practice that owns an ASC as not posing a significant risk. This view was reasonably supported by the many federal and state health care laws that afford protections to group practices.

While 03-05 does not provide for a general prohibition applicable to all group practice/ASC arrangements, it clearly has raised the stakes for an investment in an ASC by group practices when primary care physicians or other non-utilizers are part of the group. For a more detailed discussion of the regulatory issues raised by a group practice's ownership of an ASC, see § 5.03[C] and § 5.03[D].

It is worth noting that parties to an arrangement also should look to other OIG regulatory guidance as well. Indeed, there are a number of other sources for regulatory guidance beyond the safe harbors, including special fraud alerts and advisory bulletins.⁴⁴

[B] The Stark Law

Unless an exception applies, the Stark law prohibits a physician from making a referral to an entity for the furnishing of "designated health services" that would otherwise be covered by Medicare if the physician (or an immediate family member) has a financial relationship with the entity.⁴⁵ Financial relationships include ownership interests and any compensation arrangement. The Stark law applies to 11 designated categories of services (DHS).⁴⁶ Importantly, ASC-reimbursed procedures are not a DHS. Thus, the Stark law is generally inapplicable to physician ownership of an ASC.

One notable exception, however, is where the hospital and ASC enter into an "under arrangement" transaction. In such cases, the ASC provides the surgical service to the hospital. In exchange, the hospital purchases the facility component of the surgical procedure from the ASC. The ASC does not bill Medicare or any payer but rather bills the hospital for the hospital's use of the ASC's facility and other services that it renders. The hospital then bills Medicare or the other applicable third-party payer for the services rendered.

⁴⁴ See <www.oig.hhs.gov> for the OIG's Web site.

⁴⁵ See 42 U.S.C. § 1395nn.

⁴⁶ The following services comprise the 11 categories of DHS: (1) clinical laboratory services; (2) physical therapy services, (3) occupational therapy and speech-language pathology services; (4) radiology and certain other imaging services (excluding invasive radiology); (5) radiation therapy services and

supplies; (6) durable medical equipment and supplies; (7) parenteral and enteral nutrients, equipment, and supplies; (8) prosthetics, orthotics, and prosthetic devices and supplies; (9) home health services; (10) outpatient prescription drugs; and (11) inpatient and outpatient hospital services. DHS includes the professional as well as the technical component (if any) of the service.

As noted above, a surgical procedure performed in and billed by an ASC typically is not a DHS. Hospital outpatient services, however, are one of the categories of Stark law's designated health services. Accordingly, a surgical procedure could be deemed a Stark law DHS when billed by the hospital pursuant to an under arrangement transaction. In such instance, the hospital and the physicians will have an indirect compensation arrangement, which will need to be analyzed and structured in a manner that is compliant with the Stark law.

The under arrangement model has been receiving increasing attention from hospitals and physicians due to the greater differential in reimbursement rates between ASCs and hospitals that initially came into effect in 2007. Such a model, however, should not be implemented without careful legal guidance. In addition to the required Stark law analysis, it is critical to analyze the transaction structure under the anti-kickback statute and other federal and state health care laws to such an arrangement. In fact, most under arrangement transactions will likely not meet any anti-kickback statute safe harbor and thus should be closely analyzed to determine whether it is being structured appropriately.

[C] State Fraud and Abuse, Self-Referral, and Fee Splitting Prohibitions

Most, if not all states, have laws that are intended to prohibit activity substantially similar to the anti-kickback statute's fraud and abuse prohibition and the Stark law's self referral prohibition.⁴⁷ These laws are often referred to in the health care industry as "baby" or "mini" kickback and Stark laws. Most states usually also have certain additional fee splitting limitations.

[1] State Anti-Kickback Laws

In analyzing a state anti-kickback statute's application to an ASC transaction, there are three components that often distinguish the analysis from that of the federal anti-kickback statute. First, the state law is typically applicable to all payers. By contrast, the federal anti-kickback statute only applies to payments related to items and services provided under a federal health care program. Second, the state law may or may not provide for safe harbor provisions or exceptions. Third, the state anti-kickback statute may or may not have a *scienter* (e.g., knowing and willful) requirement. As discussed above, the federal anti-kickback statute requires for the government to prove that the parties knowingly entered into an unlawful transaction. The same may not be said with respect to all state anti-kickback laws. Since the wording of these statutes generally is very broad and all encompassing, the lack of an intent requirement can make

⁴⁷ For a 50-state survey of state self-referral laws, see Gary McClanahan, *State Illegal-Remuneration and Self-Referral Laws*, Second Edition (AHLA 2005).

enforcement at the state level a much easier pursuit requiring less proof than would be needed to prove a violation of the federal statute.

Many states have adopted multiple anti-kickback statutes or rules, codifying them as part of the statutes and rules regulating unprofessional conduct for licensed physicians, state workers' compensation laws, and state Medicaid laws. Accordingly, a thorough compliance check should be completed to ensure that all state anti-kickback laws have been identified and addressed.

[2] Mini-Stark Laws

Like the Stark law, state mini-Stark laws typically prohibit referrals to entities for designated health services where the physician has a financial relationship with the entity. States may differ, however, on what constitutes a designated health service. Moreover, the state law may even apply broadly to all health care items or services. States also may differ on the types of entities regulated and whether a "financial relationship" includes ownership and investment interests and/or compensation arrangements. For example, Florida provides that a physician must have an investment or ownership interest to implicate the self-referral law, but it does not address compensation arrangements.⁴⁸ This is a clear departure from the Stark law, which addresses both investment and compensation arrangements. Finally, the state law may have different exceptions or different nuances to similar Stark law exceptions.

§ 5.03 PHYSICIAN SYNDICATION

[A] De Novo ASC—Choice of Entity

In order to develop a new ASC, an entity will need to be formed to operate the ASC. The choice of entity should take into consideration the applicable state's laws, as well as the desired federal tax status. Unquestionably, over the last several years a limited liability company (an LLC) has become the entity of choice through which to own an ASC. The LLC's popularity is largely due to its ownership flexibility and favorable tax treatment. Because an LLC is taxed like a partnership, an LLC results in federal taxes paid solely at the investor level (i.e., one level of taxation). By contrast, a C-corporation is subject to double taxation (i.e., paying income tax once as the income is earned by the ASC and then again by the owners on their distributions). Moreover, an LLC is permitted to have corporate investors (which in today's hot ASC acquisition market is an important attribute). Finally, an LLC provides greater flexibility in establishing and operating new "divisions" and allocating the profits and losses of such divisions only to

⁴⁸ Fla. Stat. § 456.053 (2007).

certain owners. This structural flexibility also could prove useful in situations where an ASC's owners decide to incorporate certain ancillary services such as the provision of anesthesia services.

Notwithstanding the favorable status of an LLC, most ASCs established over 5+ years ago were historically incorporated as a business corporation or professional corporation and elected to be taxed as an S-corporation. Similar to an LLC, an S-corporation also avoids double taxation. Unlike an LLC, however, the Internal Revenue Code rules essentially limit S-corporation shareholders to human beings (i.e., no ownership by entities with limited exceptions). Thus, an S-corporation does have a drawback, which is particularly meaningful if the ASC's owners desire to sell an equity stake to a corporate investor. In such instances, as discussed in more detail later in this chapter, the ASC's owners may consider invoking some creative legal strategies.

One potential criticism of LLCs that is becoming less relevant with the passage of time—they are a relatively new investment vehicle in comparison to corporations. Thus, the laws and guidance addressing LLCs (particularly as it relates to corporate governance and addressing disputes among owners) arguably are not as developed as the laws and guidance applicable to corporations. A well-drafted governing document of an LLC, however, should address substantially all governance issues making reliance on such statutes and other laws less important. It is also worth pointing out that in the absence of case law directly on point for an LLC, a court may look to similar case law applicable to corporations as being persuasive. In any event, the benefits of an LLC typically outweigh any such criticisms or concerns.

Keep in mind that ultimately the choice of entity is governed by state law. Thus, the preferred type of entity in one state may not be preferable in another state. For example, in California, until recently, an LLC could not operate an ASC because a pharmacy permit could not be issued to an LLC. In Texas and Pennsylvania, an LLC is subject to certain taxes to which a partnership is not. In those instances, a limited partnership or limited liability partnership is often used in lieu of a corporation or LLC.

[B] Physician Syndication

[1] Physician Syndication of a De Novo ASC

A new ASC's success depends in large part on its ability to bring in the right mix of physicians through an initial syndication. The sale of equity interests is handled through a single offering using either a private or confidential offering memorandum or abbreviated risk disclosure document. An offering in an ASC

implicates certain federal and state securities laws. These transactions are typically structured to qualify under Regulation D of the Securities Act of 1933 and the corresponding state law. With limited exception, each investor should represent to the ASC that he or she qualifies as an “accredited investor” under the Securities Act. Failure of an investor to qualify as an “accredited investor” could result in the ASC incurring substantial delays and expense, as more formal disclosure requirements and filings may be needed.

In general, all physicians involved in an initial syndication should be offered the opportunity to acquire the same equity percentage on the same deal terms. Some ASCs may consider allowing those physicians who are anticipated to be greater utilizers to acquire a greater equity interest. Doing so, however, is not without regulatory risk. It is also worth noting that in a syndication of a “de novo” surgery center, the money typically goes into the ASC for the build out of the facility, equipment, and working capital.

[2] Physician Syndication of an Existing ASC

Physician owners of existing ASCs are increasingly seeking to sell equity interests to physicians who utilize their ASCs. These transactions are win-win situations for both the existing owners and the physicians who are buying in for multiple reasons. First, the ASC is better positioned to maximize its case load, since selling equity to physicians who utilize the ASC solidifies their commitment to the ASC. Similarly, these transactions allow the buying physicians to supplement their professional income by receiving their pro rata share of the ASC’s profits, which also solidifies their commitment to the ASC. Second, additional physicians’ procedures are quite profitable because the fixed costs of operating the ASC are already covered. Third, a properly syndicated ASC also could lead to the lucrative sale of a significant equity interest in the ASC to an ASC management company, health system, or other corporate investor.

[3] Sell to Several Physicians or a Select Few in an Existing ASC

The sale of interests can be handled in either of the following two ways: (i) a single offering (potentially through a private offering memorandum or abbreviated risk disclosure document); or (ii) “picking them off,” which is selling to one or two physicians at a time.⁴⁹ Each has advantages and disadvantages with respect to cost, timing, and practicality. A syndication to multiple physicians has the possibility of being less drawn out, is often more practical for larger ASCs, and can be presented as a nonnegotiable take-it-or-leave-it deal.

⁴⁹ See also Jerry J. Sokol, Esq. and Joshua M. Kaye, Esq., *Bringing in New Physician Investors, Today’s Surgicenter* (Apr. 2004).

By contrast, picking physicians off one at a time often saves the ASC the time, cost, and effort of preparing a private placement memorandum, potentially allows the ASC to justify different purchase price terms if done over an extended period of time, and could translate into less negotiation with subsequent physicians once the first few physicians fall in line.

In connection with such decision, an ASC's owners also will have to consider whether they want the monies raised from the syndication to go to the ASC or into their own wallets. By contrast to a syndication of a "de novo" surgery center, owners of an existing ASC often want to pull some cash out of their facilities at lower capital gains tax rates by selling a portion of their equity, as opposed to issuing interests from the ASC directly.

[4] Deal Terms and How Much Should Be Sold to New Physicians

When syndicating an existing ASC, a threshold decision to be made by the current owner(s) is to either (1) treat new physician owner(s) in the same manner as the current owner(s), even if the new owner(s) buy less and therefore hold minority equity interests; or (2) create equity that is not as favorable as the equity of the current owner(s) (i.e., the "Founding Physician Owner(s)" concept discussed later in this chapter). On occasion, an ASC that is utilized by multiple physicians may be owned by one or two physicians. In such instances, the goal of a successful syndication is to sell enough to secure the ASC's relations with existing and new utilizing physicians and ensure that such physicians are committed to the ASC. At the same time, the founding physician owner(s) also will want to keep enough interests to retain control, reserve enough to sell to other physicians at a later date, and maintain enough to maximize the amount of interests that can be sold to a corporate investor at a later date for a higher price.

[5] Determining the Purchase Price—De Novo and Existing ASCs

In a de novo or start-up facility, the purchase price for an interest in an ASC is typically based on the amount of funds needed by the ASC for development and initial working capital that the ASC was unable to borrow. For example, if the development of a new multi-operating room ASC costs \$4,500,000 (inclusive of three to six months of working capital) and the ASC obtains a loan of \$3,000,000, then the ownership interests of the ASC would be sold for a total of \$1,500,000 or \$15,000 for a one-percent interest.

The purchase price for an equity interest in an existing ASC is typically based on the following formula: (1) the ASC's earnings before interest, taxes, depreciation, and amortization (EBITDA) for the 12-month period preceding the buy-in date, multiplied by (2) a multiple; less (3) the ASC's long-term debt; multiplied by (4) the percentage being acquired. For a mature ASC, this often can result in a significant purchase price. For example, suppose a talented surgeon currently

utilizes an ASC. The ASC's existing owners have expressed an interest in this physician and desire to sell her a five percent interest in the ASC. Suppose further that the ASC has a trailing 12-month EBITDA of \$1,000,000 and long-term debt of \$500,000. Finally, assume that the fair market value multiple for a minority interest in an ASC is around a three multiple. In such case, the purchase price would equal \$125,000 (i.e., \$1,000,000, multiplied by three, less \$500,000, multiplied by 5 percent). That's a sizeable check to write, even for a successful doctor.

Indeed, it is quite common for a physician to resist and argue that the ASC should offer the interests at a discounted price. Certainly, legitimate business arguments exist supporting such a case. After all, she essentially increased her own purchase price by performing procedures at the ASC and contributing to the ASC's revenue.

For regulatory reasons, however, the purchase price for each equity interest must be at least fair market value. With limited exception, failing to sell the interests for at least fair market value to a utilizing physician would produce a significant level of risk under the anti-kickback statute. The concern under the anti-kickback statute is that the ASC or its owners are selling the equity interest to the physician at a discount in order to induce her to start or continue to use the ASC. Under the statute, the discounted price could be deemed prohibited "remuneration" to the physician in order to induce her referrals. Compliance with the fair market value standard is clearly one of the most critical regulatory obstacles that an ASC faces that has a direct impact on the ASC's business success.

[C] Departing from Fair Market Value and the Group Practice Safe Harbor

Notwithstanding the general fair market value requirement, there are potential methods that could afford some ASCs relief to price ownership interests below fair market value without creating meaningful health law regulatory risk. First, group practices that have enough surgical volume to justify an ASC affiliated solely with that practice might be able to depart from the fair market value requirement. Such ASCs are more prevalent in certain specialties such as gastroenterology and ophthalmology. The position is based on the "group practice" and "extension of practice" concepts.⁵⁰

In considering whether to depart from the fair market value requirement, certain elements should be present, including the following:

1. All of the physician owners of the ASC must be members of the same single or multispecialty group practice.

⁵⁰ See also Jerry J. Sokol, Esq. and Joshua M. Kaye, Esq., *Legal Update: Can a Group Practice Own a Surgery Center?*, *Outpatient Surgery* (June 2004).

2. Each physician owner should be in a position to derive a substantial portion of his or her income from the performance of ASC procedures (for example, no nonutilizer physician owners, such as primary care physicians who provide referrals to the utilizing physicians).⁵¹

In particular, the anti-kickback statute has a safe harbor for a physician's investment in a group practice. Arrangements in which physicians from a single group practice have ownership in a separate ASC entity will not meet this safe harbor because, by its terms, the safe harbor only applies to investments in the group practice entity itself and not to ancillary ventures owned by the group or its physicians.

The group practice safe harbor, however, does not require the investments in the group practice to be at fair market value. Furthermore, the ASC safe harbors do not explicitly require that an ASC investor pay fair market value for an interest in the ASC. Rather, the ASC safe harbors require that the terms on which an investment interest is offered to an investor must not be related to the previous or expected volume of referrals.

Depending on the specific facts and circumstances underlying the transaction, ASCs owned by group practices may consider selling equity to new group practice owners at a price lower than fair market value. In such instances, the price might be based on some other value (perhaps the book value of the ASC's assets) or some other objective formula that has been set in advance and is unrelated to the investor's volume of referrals to the group practice's ASC. As stated above, while this option may be an option worth considering, it is not without risk. Departing from fair market value should depend on the specific factual circumstances underlying the group practice's situation and the parties' risk tolerance.

Another method of potentially lowering the purchase price is based upon a concept borrowed from the private equity world. The concept is referred to as a dividend recapitalization or "dividend recap." Because an ASC's debt is part of the purchase price formula, increasing the ASC's debt will reduce the purchase price and still allow the ASC's owners to pull out nearly the same amount of cash that they would have otherwise received had the interests been sold for fair market value. A word of caution—consult an ASC's business, legal, and tax professionals when considering a dividend recap since the borrowed cash is paid out to existing owners as a dividend, which may not be looked upon favorably by creditors. Also, should interest rates rise, the option of a dividend recap could become less attractive.

⁵¹ See § 5.02[A][3][b][iii] for a discussion of
OIG Advisory Opinion 03-05.

[D] Other Advantages of ASC Ownership Through a Group Practice

Physician owners of an ASC receive distributions on the ASC's profits in accordance with their pro rata ownership interest in the ASC. As discussed above, it is quite common for physician owners of an ASC to desire to reallocate the ownership of the ASC in a manner that is more consistent with each owner's relative utilization of the ASC. Due to limitations under the anti-kickback statute, those who engage in the re-shuffling of ownership interests do so with material regulatory risk.

To the extent an ASC is truly owned by a group practice, there may be some relief here as well. In a group practice, ancillary service revenue from such items as clinical laboratory, medical imaging, and physical therapy are often pooled and may, under the Stark law, be divided among the group practice's physicians according to the relative professional fees (i.e., an "eat what you kill" compensation formula) generated by each physician as long as such allocation is not directly tied to referrals for the ancillary services. From a Stark law perspective (as well as most state fraud and abuse laws), such a compensation formula is generally permissible subject to certain limitations that are beyond the scope of this chapter.

To the extent that an ASC is owned by a group practice, that same compensation formula arguably could apply to the revenue generated by a group physician for his or her use of the group practice's ASC, assuming such an allocation is preferable to an allocation based on relative ownership. This could prove tremendously useful for single-specialty practices, such as in ophthalmology or endoscopy practices, or even very large multispecialty group practices, where in each case the practice is the owner of the ASC. Importantly, a group practice that is considering this concept must directly own the ASC. By contrast, the other benefits of owning an ASC discussed in this section may not require the ASC to be owned by the group practice as long as the ASC is owned by the physicians of a single group practice.

It is worth noting that many attorneys caution against mixing assets (i.e., having the ASC and the physician practice owned under a single entity) due to malpractice exposure and other concerns. The clear advantages of allowing the ASC's profits to be distributed in a manner discussed above may outweigh such risks or concerns, which might otherwise be dealt with through careful and deliberate asset protection planning.

[E] Paying the Purchase Price

With respect to the manner of payment, clearly the best way to handle this from a regulatory perspective is to have the physician pay the purchase price in cash. If financing is necessary, the buying physician or other investor should borrow from a bank or other third-party lending source. The reason for this is that the anti-kickback statute ASC safe harbors contain a criterion that neither the ASC nor any other owner may loan funds to a physician to enable him or her to acquire

the equity interest in the ASC. The government typically desires for the physicians to have really placed their money at risk and have not been allowed to participate in an ASC with “no money down.”

§ 5.04 REDEMPTION OF PHYSICIAN INTERESTS

[A] Overview

The redemption or buy-back of interests from physician investors raises both important business and regulatory issues. Redemption provisions are contained in the ASC’s governing document. Having the right governing document with all the appropriate provisions is critical to both the ongoing profitable operation of the ASC and facilitating and simplifying future transactions, such as the sale of an equity interest to a corporate investor. The name of the governing document depends on the type of entity operating the ASC. If the ASC is organized as an LLC, the governing document is referred to as an operating agreement. If the ASC is formed as a limited partnership, then the governing document is called a partnership agreement. If the ASC is incorporated as a corporation, then the governing document is referred to as a shareholders’ agreement.

In addition to redemption provisions, the following key terms and concepts should be considered when creating a governing document: (1) the founding owner(s) concept, (2) control and decision making of the ASC, (3) rights and restrictions on the transfer of equity, and (4) a noncompete provision and other restrictive covenants. Each of these concepts, along with the redemption provisions, is addressed below in more detail.

[1] Redemption Provisions

The governing document should provide that if certain events—called triggering events or redemption events—occur to a physician owner, the ASC or its owners will have the right to redeem or buy back such owner’s equity in the ASC. In short, redemption provisions deal with the issue of how to remove an investor. Because the business of an ASC is largely predicated on physician productivity, ASCs have increasingly focused on the use of redemption events as a means to eliminate physicians who do not utilize the ASC as an extension of their practices.

Redemption events can generally be divided into the following three categories: (1) those events beyond a physician’s control, (2) those events caused by the physician owner (a.k.a. for cause redemption events), and (3) a redemption caused to one physician owner as a result of a vote of the other physician owners (i.e., a redemption without cause). Quite often the category of redemption event will affect the price and other terms of the redemption.

The first category addresses the redemption events of death or disability. Retirement and relocation are sometimes treated in the ASC’s governing document in the same manner as death or disability, although that is becoming increasingly uncommon.

The second category of redemption events relates to bad acts or “for cause” events. There is typically a laundry list of “for cause” redemption events in an ASC’s governing document. Such events include an investor’s breach of the restrictive covenants or other terms of the agreement, a physician investor’s loss of staff privileges at the ASC, a physician’s loss or suspension of his or her medical license, or conviction of or entering of a plea of *nolo contendere* to a felony or any health care crime.

To the extent the ASC is owned by a single group practice, the group practice may also want to consider including a cross-default provision that would allow the ASC to acquire the interests of a physician investor whose employment with the group practice has been terminated. Otherwise, the ASC’s remaining owners (typically the same doctors who own the group practice) could be in the precarious position of having a terminated physician still being a partner in the ASC.

There are five additional redemption events that have the added advantage of eliminating non-productive physicians as well as those physicians who are not “team players.” Each of the following could also implicate some concerns under the anti-kickback statute if improperly designed or implemented. First, many ASCs or their owners have the right to redeem the ownership interests of a physician who fails to meet the one-third income test for a single-specialty or multi-specialty ASC. Additionally, many ASCs incorporate provisions in their governing documents that give the ASC the right to redeem the interests of a physician who fails to meet the one-third procedures test of a multispecialty ASC. Both of these redemption events should closely follow the wording of the one-third tests from the ASC safe harbor. Both the one-third income test and one-third procedures test are discussed in detail earlier in this chapter.

Some single-specialty ASCs involved in a specialty that arguably has multiple sub-specialties have also incorporated the one-third procedures test as a redemption event. For example, an ASC specializing in ophthalmology may have multiple physicians with sub-specialties. As discussed earlier, the one-third procedures test is intended to ensure that in a multispecialty ASC, a surgeon investor is not simply a referral source to other surgeon investors. This same concern could arise in a situation where a single-specialty ASC involves multiple sub-specialties, and thus arguably serves as a basis for incorporating the one-third procedures test into a single-specialty ASC’s governing document.

The primary principle of the one-third tests is to ensure that each physician investor is using the ASC as an extension of their practices. Thus, incorporating the one-third tests as redemption events arguably enables an ASC to ensure that the ASC and its physician-investors are complying with an element of the ASC safe harbor.

Such redemption events also arguably provide the ASC with the ability to redeem physician investors who are no longer real users of the ASC. Physician investors who are not satisfying either of the one-third tests have likely become

less productive but still receive their share of the ASC's profits. This could result in a drain on the ASC's resources and often breeds discontent among the remaining physician owners. Accordingly, by requiring the physician owners to comply with the ASC safe harbor's one-third tests, the ASC also better ensures that its physicians are utilizing the ASC as an extension of their practices.

It is not uncommon for a physician investor whose interests are being redeemed as a result of failing to comply with either of the one-third tests to cry foul and take the position that he or she is merely being penalized for underperformance in violation of the anti-kickback statute. Such an argument may have some merit, particularly if the redemption events are being selectively enforced, meaning they are being applied to one physician owner but not the other. In such instances, it becomes more challenging for an ASC to take the position that the redemption event is being applied to ensure safe harbor protection. There may, however, be some commercially reasonable justifications for selective enforcement. Short of such issues arising, it would seem inappropriate for the government to penalize an ASC that uses the one-third tests as redemption events in an effort to comply with the standards the government itself has set forth in the ASC safe harbor.

One of the more challenging issues related to the one-third tests is measuring compliance with the one-third income test. Since it is a measure of a physician's professional income from all sources, it is generally difficult, if not impossible, for an ASC to measure such compliance without the physician investor's cooperation. In that regard, an ASC's governing document often requires each physician owner to make an annual attestation that he or she satisfies the one-third tests. The governing document also may provide the ASC with the right to audit the physician's financial records from his or her practice to confirm that the physician is complying with such standards. This latter requirement, however, might be looked upon poorly by physician investors and can be particularly difficult to accomplish if the physician is part of a larger medical practice.

Such a requirement also can be particularly troubling in a hospital/physician joint venture where the hospital is trying to build a stronger level of trust and a relationship with its physicians on the one hand while requesting that it have the ability to audit the physician's professional practice on the other hand. It also could implicate certain anti-trust concerns if the hospital will have access to payer information of the physician practice.

There is another alternative that may be worth considering. In today's market, many ASCs are managed by a management company and/or have an independent company performing the billing and collection activity. An ASC may be in a better position to measure each physician owner's compliance with the one-third tests in those instances where each physician investor also uses the same management or billing company for their private practices.

As an alternative or in addition to incorporating the one-third tests as redemption events, the governing document could require that a physician

investor's interests in the ASC could be acquired if he or she does not utilize the ASC as an extension of his or her practice. The basis for using such a standard is twofold. First, similar to the one-third tests, it is intended to ensure that each physician owner is using the ASC as an extension of his or her practice, which is one of the principles that the government has espoused as favorable for acceptable physician ownership in an ASC. Thus, its intention is arguably consistent with the one-third procedures test. Second, it may allow for some greater flexibility than the more objective one-third procedures test. On the other hand, such a standard is more subjective than the one-third procedures test and therefore may be more difficult to monitor and enforce.

Some ASC governing documents afford the ASC the option to redeem a physician owner's interests if his or her professional productivity significantly decreases from historical levels. Possible benchmarks include a measure of the physician's professional revenue or RVUs. For example, if a physician's professional revenue falls below 50 percent of the level of his or her historical professional revenue, then the ASC would have the option to redeem such physician's interests. Such redemption events, however, may raise concerns under the anti-kickback statute because they relate to a doctor's productivity. On the other hand, it is not a measure of how many procedures the physician is performing at the ASC and thus could arguably be a commercially reasonable standard related to, among other matters, quality assurance. Notwithstanding such arguments, careful legal guidance is suggested whenever incorporating a redemption event that could be construed as penalizing a physician for not utilizing the ASC.

The final category of redemption events would allow the ASC or its owners to redeem the interests of a physician investor "without cause" upon the affirmative vote of the holders of a certain ownership percentage of the outstanding interests of the ASC. Because this redemption event would apply regardless of whether a physician investor did any bad act, it is often subject to a supermajority vote (e.g., 75 + percent) of the owners. A redemption without cause is sometimes criticized as being a scheme to eliminate nonproductive physicians. To the extent it is utilized for that purpose, certain regulatory concerns do arise. Such redemption provisions, however, are often used as a failsafe method to eliminate those physician investors who are a disruption to the ASC but know how to stay on the fine line of the governing document so that no other redemption event applies. At least one court has upheld such a provision in the context of the redemption of a physician's ownership interests in an ASC.⁵²

In addition to determining the litany of redemption events, the governing document also should set forth the manner in which the redemption price is

⁵² See *Mixon v. Iberia Surgical LLC*, No. 06-878 (La. Ct. App., Apr. 18, 2007) pursuant to which court upheld redemption of physician owner's interests who was an alleged whistle-

blower when the ASC's governing document permitted his redemption upon a unanimous approval of the other owners.

calculated as well as the payment terms. The redemption price can be calculated in a number of ways, including by a formula, an appraisal, or based on a set dollar amount to be adjusted on an annual basis. The recent trend is to base the redemption price on a multiple of the EBITDA less the ASC's long-term debt determined as of the date of the redemption event. (i.e., the same formula typically used to buy an interest in an existing ASC).

Assuming the physician being redeemed ceases to be a potential referral source, there is no regulatory requirement for the redemption price to be consistent with fair market value. Indeed, another recent trend is for the redemption price to be further discounted if the physician's interest is being redeemed due to some bad act (such as breach of noncompete). Departing below fair market value for purposes of redemption, however, is a general proposition. Certain regulatory concerns could arise in situations when the redemption price is below fair market value and the redemption event is tied to a physician's failure to use the ASC as an extension of his or her practice. Each individual situation should be carefully analyzed under current regulatory guidance.

On occasion, an ASC may consider having the redemption price set at above fair market value for certain redemption events. For example, if the ASC's founding physician owner(s) are more senior and close to retirement, then they may seek for the governing document to provide for a higher multiple of EBITDA upon a physician's retirement. Doing so could raise regulatory concerns, however, if the basis for the redemption price is not in any manner correlated to the basis for computing the price at which an interest in an ASC is sold to a new physician investor around the same time as the redemption. If the redemption price is greater than the buy-in price paid by another physician to acquire an interest around the same time as the buy-out, one might infer that the buy-in price was set at less than fair market value to induce the new physician-investor to use the ASC in violation of the anti-kickback statute. By way of illustration, if the buy-out price was based upon five times EBITDA for the departing doctor upon her retirement and a new doctor is required to pay substantially less to acquire his or her interests in the ASC around the same time as the departing doctor's redemption, that could implicate concerns under the anti-kickback statute.

Typically, the redemption price paid for death, disability, retirement, and redemption without cause are more favorable than the price paid as a result of a for cause redemption event. With that said, there is an increasingly prevalent trend of treating a physician's investment in an ASC as an opportunity to generate and receive additional profits while contributing to the ASC's success but with no lucrative buy-out upon such physician's departure.

Redemption formulas that are based upon a multiple of earnings are typically based on the ASC's historical EBITDA for the 12-month period immediately preceding the redemption event. It may, however, be worth considering basing the redemption price on the EBITDA for the 12 months immediately following the redemption event. In this manner, the price would not be determined or fully paid until one year after the redemption. This can help to protect

the ASC's financial viability since the ASC's earnings will likely decrease as a result of the redeemed physician no longer performing procedures at the ASC.

Some ASCs cap the amount that may be paid for redeemed interests in any calendar year. For example, some ASC governing documents provide that no more than 15 percent of the distributable cash will be paid in any calendar year to a redeemed physician. Otherwise, the ASC could be paying the lion's share of its cash to departing physicians at the expense of those physician investors who remain committed to the ASC. Additionally, rather than forcing the ASC to compromise its liquidity, the ASC often has an option to pay the redemption price over time (e.g., one to three years) rather than in a single lump sum at the time of redemption.

[2] Dealing with Dead-Weight Physicians and the Squeeze-Out Merger

Few things can lower the morale of an ASC as much as a physician partner who does not use the ASC as an extension of his or her practice yet collects dividend checks and continues to be involved in the decision making of the ASC. As discussed above, by incorporating the one-third tests and other redemption events into the governing document, many ASCs are able to repurchase the ownership interests of such physicians.

Many ASCs (particularly those that were established prior to the promulgation of the anti-kickback statute safe harbors for ASCs), however, were set up without this foresight and as a result have struggled with trying to buy back the interests of such physicians. In such instances when the ASC's governing document does not provide a basis for redemption, the ASC typically tries to negotiate a buy-out of those physicians' ownership interests. This rarely works for two primary reasons. First, the physician whose interest is trying to be redeemed is likely aware of the large multiples being paid by ASC management companies and will want to receive the same type of premium for his or her interest, which the ASC is likely unwilling to pay. Second, the physician will want to continue reaping a return on his or her investment through continued dividends.

Having failed to negotiate a buy-out, some ASCs may then try to use the physician's noncompliance under the anti-kickback statute to force the physician to leave. In such instances, the physician may receive a letter from the ASC or its legal counsel indicating that such physician can no longer be an owner because he or she is not using the ASC as an extension of his or her practice in accordance with the principles promulgated by the government with respect to the ASC safe harbor to the anti-kickback statute. This strategy is often unsuccessful, however, because among other matters, the ASC often is not satisfying other elements of the applicable ASC safe harbor nor is such physician a referral source to the other physicians, which could undermine the ASC's position that the basis of the redemption is for regulatory compliance.

An ASC may then review its governing document to see whether it can amend such agreement to incorporate the requisite redemption events. Since

amending the governing document often requires a unanimous vote of the physician owners, this, too, is generally unsuccessful. Even if the agreement can be amended by less than a unanimous vote, it is questionable whether such amendment would be enforceable against a physician who did not approve the amendment. On the one hand, such physician owner agreed that the governing document could be amended without a unanimous vote, and the duly authorized amendment arguably should be enforceable even against those who did not approve of it. On the other hand, the amendment could be construed as an attempt to eliminate a physician owner who did not consent to the amendment. In certain instances when the physician owner has decreased his or her use of the ASC, this could be looked upon unfavorably by a court or regulator from both a corporate law and health care regulatory perspective. Having had no success with any of the above strategies, many ASCs resign themselves to the fact that they cannot force a sale by these physicians in the absence of a specific contractual provision enabling them to do so.

A successful mechanism has been developed that allows the ASC to eliminate (or squeeze out) these physicians through a properly approved transaction. The process essentially involves two steps. First, a new entity is formed to be owned solely by those physicians who are intended to remain with the ASC (“Newco”). Newco is capitalized with enough money to pay the other physicians being squeezed out fair market value for their equity in the existing ASC. Newco’s capitalization can be obtained through money provided by the physicians who formed Newco, borrowing it from a lender or perhaps obtaining it from a corporate sponsor who desires to participate in the ongoing ASC after the squeeze out is completed.

Second, the existing ASC and Newco each approve a plan to merge together. This plan should spell out the fair market value cash payments to the nonutilizers and provide that the physician owners of Newco will receive equity in the surviving entity. Absent a governing document providing to the contrary, state laws generally require that a merger be approved by the holders of a majority of the equity interest in the existing ASC and Newco. Accordingly, a squeeze-out merger can be performed only if the parties can obtain the requisite vote to authorize the merger. If, for example, the governing document of the existing ASC requires that the approval of a merger be subject to a higher voting threshold (which is often the case) and the squeezed-out physicians have enough of such vote to block the merger, then a squeeze out cannot be effectuated. By contrast, assuming those physicians desiring to effectuate the squeeze-out merger own enough of the ASC’s equity to meet the voting threshold, then they can approve the transaction and effectuate the squeeze-out merger. To be clear, the squeeze-out merger cannot be done if the physicians who are being squeezed out can block the merger as a result of owning enough equity in the existing ASC to defeat the approval of the merger.

While this transaction may seem complicated at first glance, it is actually pretty simple and easy in practice. Moreover, by designating the existing ASC to

be the surviving entity, the squeeze-out transaction does not impact the ASC's Medicare number or payer contracts. Assuming the plan of merger identifies the existing ASC as the "surviving entity," the ASC will continue to operate under the same employee identification number, Medicare provider identification number, and so on.

A squeeze-out merger is permitted under most state laws as long as the cash to the "squeezed-out" owners equals fair market value for their equity interests.⁵³ So what happens if the squeezed-out physicians sue? Most states prescribe that all owners of a company be treated fairly but not necessarily equally. Moreover, most states' corporate laws give owners in privately held companies very few rights other than those that they contractually negotiated for pursuant to the company's governing document.

Thus, if properly implemented, most states would entitle the squeezed-out physicians to the difference (if any) between the court-determined fair market value of the squeezed-out physicians' equity interest in the former ASC and the amount that they actually received. This concept is often referred to as a dissenter's rights claim, which is the right of an owner who dissented in a vote for a particular transaction to bring a claim to make sure that he or she is paid a fair price. As a result, it is highly advisable and really a requirement for the ASC to obtain an independent fair market value appraisal as the basis of the amount paid to the squeezed-out physicians.

In practice, even the threat of a squeeze-out merger can often serve as the catalyst for a successful negotiation of the buy-back of the equity interests of physicians who are intended to be squeezed out. While in the past many ASCs have figured there was not much that could be done, the squeeze-out merger now provides a new tool to consider in dealing with physicians whose ownership interests cannot otherwise be redeemed.

A squeeze-out transaction may be structured slightly differently depending upon the existing ownership structure and each state's corporate laws. Tax consequences may also impact the structure of the transaction. Thus, it is critical to carefully analyze the laws of the applicable state in which the ASC is located prior to effectuating a squeeze-out merger as well as to discuss the tax implications with the ASC's financial advisors. These transactions also may raise potential regulatory concerns to the extent they are utilized to eliminate physicians who are no longer utilizing the ASC as an extension of their practices (which is often the case), and so careful legal review should be undertaken prior to effectuating a squeeze-out merger.

⁵³ See e.g., *Welsh v. Via Christi Health Partners, Inc.*, No. 92,867 (Kan. 2006).

[B] Founding Owner(s) Concept

The founding owner(s) concept essentially provides the founding owner(s) of an ASC with certain rights and carves out their ownership interests from certain restrictions imposed on the other ASC owners. In essence, this concept involves creating two classes of ownership—the founding owner(s) and all other physician owners. Generally, the founding owner(s) concept applies to an initial key investor or group of investors the ASC is built around or who are integral to the ASC's continued viability.

There are a number of areas where the founding owner(s) may receive more favorable rights under the governing document. It is very common for the founding owner(s) to have greater control over the operations of the ASC. This can be accomplished by providing the founding owner(s) with the contractual right to control decisions affecting the ASC and/or providing the founding owner(s) with the right to veto decisions. Additionally, the founding owner(s) might not be subject to certain transfer restrictions that limit the transferability of other physician investors' interests. In that regard, the founding owner(s) often have at a minimum the right to sell their interests to a corporate investor. Without such right, the other physician owners would have the leverage to undermine the founding owner(s)' sale of a significant equity stake to a corporate investor. The founding owner(s) also can be exempt from certain redemption events (discussed in more detail above in this section) or receive more favorable buy-out terms if a redemption event is triggered.

[C] Control and Decision Making

It is essential that the governing document be clear regarding control and decision making of the ASC. If the ASC does not have a governing document or the governing document is silent as to how decisions are made, then control defaults to a simple majority of the ownership interests. Given the intricacies of ASC management and the desire of investors to have certainty as to how the ASC will be governed, a specific structure for control and decision making should be clearly established in the governing document.

Regardless of which control structure an ASC adopts in its governing documents, there is often some protection afforded to minority investors. Physicians may be less likely to invest funds in an ASC if their equity interests are subject to the whim and will of another party. Generally, protection of "minority" investors takes the form of a "supermajority" requirement for certain significant decisions or actions. Thus, rather than a simple majority of the ownership interests or management board votes, specified decisions would require a certain, heightened, level of approval. The approval required for "supermajority" votes varies but typically ranges between two-thirds and three-fourths of all ownership interests. The percentage is often set at a threshold that requires at least some minority owners to approve the action in addition to the majority owners.

Decisions that are subject to a supermajority vote vary. One of the most common decisions requiring a supermajority vote is the sale of substantially all of

the ASC's assets, the sale of equity in the ASC, or a merger with another entity. The following is a list of some other key decisions that are commonly subject to a supermajority vote:

- The issuance of ownership interests in the ASC;
- The admittance of any additional members or establishing any additional classes of members;
- The filing for bankruptcy or other creditor protection;
- Incurring debt in excess of a certain dollar threshold or making a capital expenditure in excess of a certain dollar threshold; or
- Any call for additional capital.

[D] Restrictions on Equity

[1] Transfer Restrictions

An important provision in any governing document is a restriction on the ASC owners' ability to transfer their interests to other individuals without going through some sort of approval process, such as getting the consent of a specified percentage of owners or managers. Transfer restrictions give the ASC control over who is permitted to invest in it, which is critical in light of the importance of solidifying the ASC's relationship with its utilizing physicians. If it is too easy for an investor to transfer his or her interests, the ASC could end up with an undesirable investor.

By way of illustration, suppose that two physician owners develop an ASC, each owning 50 percent and each anticipating that the other will produce 50 percent of the revenue. Suppose further that one of the owners decides to sell his or her interests to a private business person and the governing document does not prevent him or her from doing so. The remaining physician owner continues to generate the same amount of revenue. Without a transfer restriction, that revenue now reflects 100 percent of the ASC's revenue rather than 50 percent. Yet, the remaining physician owner would now share that revenue with the business person. Obviously, this would be a bad situation for the remaining physician owner.

Restrictions on transfer are generally subject to a supermajority vote of the other owners. Whether or not a supermajority is required, when a founding owner(s) concept is utilized, governing documents often provide for the consent of the founding owner(s) before a transfer of ownership may occur. Some governing documents provide for a "right of first refusal" (ROFR) any time a physician investor seeks to transfer his or her ownership interests. Such a provision provides that a physician investor cannot sell his or her interest to a third party unless he or she first offers the ASC or its other physician investors the chance to match the third party's offer and they refuse.

A right of first refusal is not as restrictive as requiring investors to obtain the consent of the ASC or a supermajority of its owners or managers before

transferring their interests. It does, however, still give the ASC and its owners some level of control over who will own interests in the ASC. Sometimes, a right of first refusal provision also will require some form of approval by the owners or management. In such cases, the governing document creates somewhat of an illusion that interests are freely transferable (subject to the ROFR) when in essence they remain subject to an approval process. To the extent an ASC provides for an ROFR process without any other form of subjective approval, it should still set some criteria for the transferee. For example, with limited exception, any transferee should still be required to be a surgeon with privileges at the ASC's facility who will meet the one-third tests or otherwise use the ASC as an extension of his or her practice.

[2] Drag Along Rights

Majority owners or founding owner(s) often need the flexibility to "drag along" minority owners in order to consummate a deal. Drag along provisions are contained in the ASC's governing document and allow the majority owners or founding owner(s) to force the other physician owners of the ASC to sell a portion (typically on a pro rata basis) of their equity interests upon a sale transaction approved by the majority owners or founding owner(s). For example, suppose a founding owner owns 30 percent of the equity of the ASC and such founding owner enters into a transaction to sell 51 percent of the equity in the ASC to a corporate investor. Assuming a drag along provision is contained in the governing document, the remaining physician owners would be obligated to sell a pro rata share of their equity interests.

As a result, drag along rights can be very useful particularly when looking to sell to an ASC management company or other corporate investor. Drag along provisions often allow for a more seamless transaction instead of negotiating with investors individually and being subject to potential holdouts.

[3] Tag Along Rights

Tag along rights are essentially the reciprocal of drag along rights. They permit minority owners to participate in the sale by a majority owner or the founding owner(s) to a corporate investor on a pro rata basis with the majority owner or founding owner(s). Thus, tag along rights obligate the majority owner or founding owner(s) to allow the remaining physician owners to participate in the majority owner's or founding owner(s)' sale of an equity interest to a corporate investor.

For obvious reasons, tag along provisions are generally disfavored by majority owners and founding owner(s). Corporate investors also are not keen on such provisions to the extent they result in a significant reduction in the amount of equity owned by the physician owners. As a result, if tag along rights are included in the governing document, they are often subject to a cap so that each physician owner participating with tag along rights will still have a meaningful equity interest in the ASC after the sale transaction is completed.

[E] Withdrawal Rights

Withdrawal rights are frequently requested by physician investors but rarely granted in governing documents. Allowing physician investors to withdraw at any time with no penalty provides no benefit to the ASC and potentially leads to instability and other issues relating to turnover, which could significantly impact the ASC's viability.

[F] Restrictive Covenants

It is critical for an ASC to subject its physician owners to a restrictive covenant. The exact scope of the restrictive covenant will be determined by the agreement of the ASC's owners and by the laws of the state in which the ASC operates. In all cases, the key components of a restrictive covenant are the activity being restricted, the duration of the restriction, and the geographic area where the restriction is in effect. Generally speaking, however, all aspects of the restriction must be reasonable (which may vary in different states).

In the ASC context, a restrictive covenant focuses on the physician's ability to have financial relationships with other facilities. It should not limit a physician's ability to practice or perform procedures in another ASC, hospital, or health care facility to the extent such physician does not have a financial relationship with such ASC. While some ASCs may attempt to do so, prohibiting a physician from performing procedures at another facility could limit the restrictive covenant's enforceability and cause concerns from a regulatory perspective.

The duration of a restrictive covenant should last while the physician is an owner in the ASC and for a tail period thereafter. Tail periods typically last from between one and three years, although it is not unheard of for a tail period to be as long as five years. The longer the restriction, the more risk there is that it will be deemed unreasonable.

The geographic scope of the restriction also should be reasonable. There is a trend toward having the restrictions cover larger service areas. This may be appropriate depending on the nature of the market being served by the ASC. The territory, however, should be carefully defined in a manner that is defensible from a business perspective should a challenge arise. No matter how the scope is determined, the provision should expressly define the area being covered so there is no ambiguity or chance for confusion.

There are circumstances when certain physicians or certain arrangements are exempt from the governing document's restrictive covenants. One potential carve-out is in the case of founding owner(s) who may be exempt from the restrictions. Additionally, financial relationships existing at the time the physician becomes an investor in the ASC are often allowed to remain in effect, but this generally is negotiated on an individual basis. In such instances, it is advisable to place limitations on the carve-out. For example, if a physician investor has a 5 percent interest in a competing facility, then such competing interest is carved out

as long as the 5 percent does not increase. Nominal ownership in publicly traded companies are also generally excepted from the restrictive covenants as well.

In addition to the noncompetition covenant, there are a number of other restrictions an ASC may want to consider. For instance, an ASC's governing document may also prohibit the physician owners from soliciting employees, patient suppliers, and virtually all other persons with whom the ASC has a business relationship. By doing so, the ASC will have additional legal comfort that a departing physician will be less inclined to attempt to raid the ASC's staff and other business relationships.

§ 5.05 SALE TO A CORPORATE INVESTOR

[A] Attraction of Corporate Investors

There has been no slow down in ASC transactions with corporate investors. These deals are attractive to physician owners of ASCs for a variety of reasons. First, corporate investors are often willing to pay a purchase price premium when acquiring an interest in an existing ASC for which they receive control and minimal restrictions on their interests. In terms of a multiple, that generally equates to a five+ multiple (and currently, many transactions involve multiples far in excess of five). By contrast, a sale of a minority noncontrolling interest to physicians with substantial restrictions on liquidity and risk of forfeiture upon certain events often involve multiples in the two to three range.

Second, the time value of money is a factor in receiving the purchase price up front. In other words, rather than waiting to earn the money over a period of years in the form of profit distributions, the selling ASC owners can receive a lump sum purchase price up front. Third, the purchase price proceeds are afforded preferable tax treatment as capital gains (currently 15 percent) on the investment interest rather than being taxed at the ordinary income rate (currently up to 35 percent) that would apply to ongoing distributions. Fourth, a corporate investor typically allows the selling physicians to retain some equity in the ASC, thereby allowing them to continue to receive distributions on their continued ownership interest. Fifth, a corporate investor will often further syndicate a portion of equity interests to new physicians. This often enhances the profit distributions paid on the equity that the physician owners retain. Finally, ASCs are usually in need of qualified management that can enhance operations and profitability and provide necessary capital. This need has fueled continued growth in the ASC management company industry.

[B] Corporate Investors

There are different types of corporate investors in ASCs.⁵⁴ There are large national ASC management companies, such as Symbion, NovaMed, AmSurg, and United Surgical Partners. A number of smaller, more regional ASC companies also

⁵⁴ See also Joshua M. Kaye, Esq., *Choosing the Right Partner to Invest in Your ASC*, Today's Surgicenter (Nov. 2005).

have emerged over the last few years and are competing with the large national companies for acquisitions. These companies tend to concentrate in certain geographical areas, and some may prefer to focus on developing new ASCs rather than acquiring existing ASCs. Figure 5-2 sets forth a list of select national and regional ASC management companies.

Figure 5-2: Select National ASC Companies

ASC Management Company
HealthSouth Corporation*
AmSurg Corporation
United Surgical Partners International
HCA, Incorporated
Nueterra Healthcare
Symbion, Incorporated
SurgCenter Development
NovaMed, Incorporated
Foundation Surgery Affiliates

13 Other Select National and Regional Companies

Surgem	Surgery Partners
Cirrus Health	National Surgical Care
Titan Health Corporation	Physicians Endoscopy
Meridian Surgical Partners	Pinnacle III
Ambulatory Surgery Centers of America	Woodrum/ASD
Blue Chip Surgical	Healthmark Partners
Health Inventures	

* In March 2007, HealthSouth announced that it is selling its outpatient surgery division to Texas Pacific Group. As of the date of this chapter, the name of the new entity that will operate the ASCs is unknown.

While many hospitals and health systems historically have viewed ASCs as direct competitors, hospitals are increasingly partnering with physicians to form ASCs through joint ventures. Often these joint ventures provide “closed” or

“semi”-private investment opportunities solely for the hospital’s medical staff or certain specialties of the medical staff. Hospitals generally prefer to engage in a de novo or start up ASC joint venture, as opposed to buying an equity interest in an existing ASC. Hospitals and health systems, however, are clearly becoming more competitive with the ASC management companies, particularly in connection with an ASC located in the hospital’s market.⁵⁵

[C] Structuring Transactions with Corporate Investors

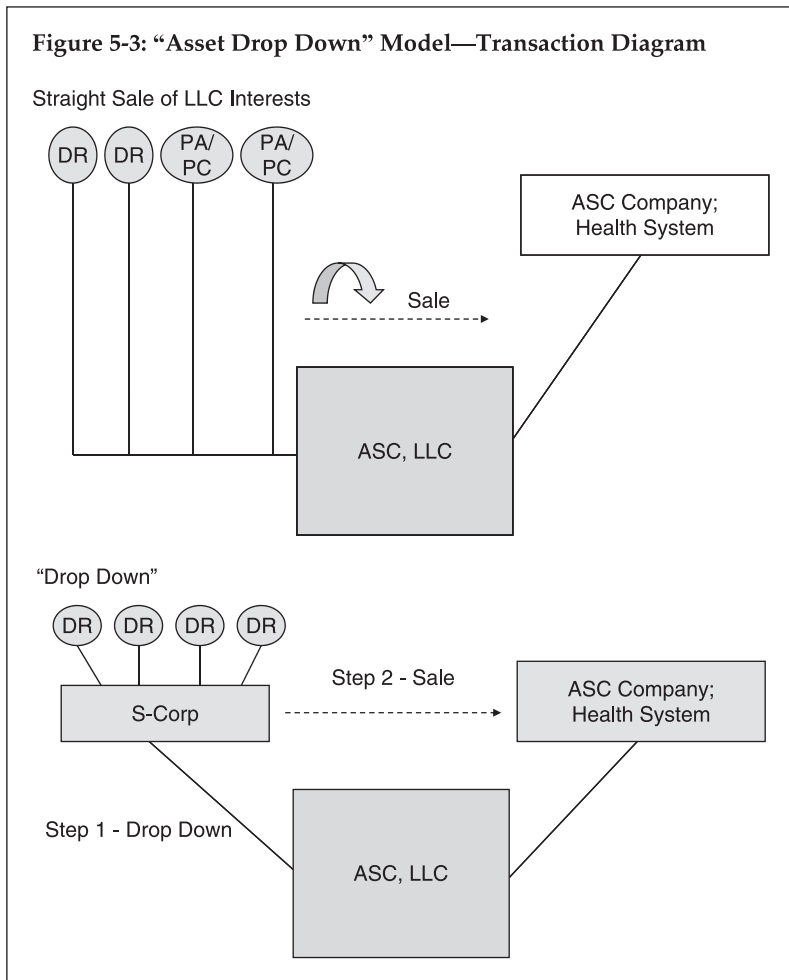
The transaction structure for selling an equity interest in an existing ASC to a corporate investor will depend on the corporate structure of the ASC. The simplest form of transaction involves the corporate investor acquiring an interest directly in the existing ASC.

When the existing ASC is formed as a subchapter S-corporation, the transaction can be a bit more complex because a for-profit corporate investor cannot be an owner of an S-corporation. In such instance, most ASCs are under the impression that they should simply convert the S-corporation into an LLC. Before doing so, however, be sure to discuss such an approach with your ASC’s legal and tax advisors. From a tax perspective, a conversion will typically be considered a liquidation. This results in phantom, but taxable, gain to the physician owners for their portion of the entire value of the ASC. Thus, the conversion unnecessarily penalizes physician owners by making them pay a tax bill on the entire value of the ASC for a transaction for which they received limited income (or perhaps no income in the event the purchase price proceeds are intended to be paid to select physicians).

To avoid or otherwise minimize such inequitable tax consequences, one strategy to consider that has been quite successful is the “asset drop down” model. This model involves the transfer of substantially all of the assets of the ASC into a new limited liability company or limited partnership (“Newco”) prior to consummating the transaction with the corporate investor. In exchange for the transfer, Newco issues a 100 percent ownership interest to the entity that operated the ASC (the S-corporation). The S-corporation then sells an ownership interest in Newco to the corporate investor in exchange for the purchase price paid by the corporate investor. Figure 5-3 provides a transaction structure diagram of both a direct sale of equity transaction versus the “asset drop down” model.

The purchase price proceeds are then paid to the owner(s) who intended to sell their equity interests in the S-corporation to the corporate investor. The end result—Newco becomes the entity operating the ASC. Newco is owned in part by the S-corporation that operated the ASC and in part by the corporate investor. The S-corporation continues to be owned by physician utilizers of the ASC.

⁵⁵ See also Jerry J. Sokol, Esq. and Joshua M. Kaye, Esq., *Medicare/Medicaid: Medicare Changes Likely to Ignite Interest In Joint Ventures*, Healthcare Financial Management (Jan. 2007); Joshua M. Kaye, Esq., *Key Aspects of a Successful Physician-Hospital ASC Joint Venture*, Today’s Surgicenter (Sept. 2005).



There is another advantage of the “asset drop down” model, in addition to its tax benefit. Corporate buyers are becoming increasingly concerned with successor liability due to Medicare overpayments or other liabilities. In the past, such concerns were addressed contractually by requiring the seller(s) to agree to indemnify the buyer for any damages that the buyer incurs as a result of such liabilities. Such contractual rights, however, may not give a buyer the regulatory and business comfort that it seeks. By utilizing the “asset drop down” model, a new entity with a new employer identification number and new Medicare provider agreement will operate the ASC on a going-forward basis. As a result, the risk of successor liability is reduced.

Notwithstanding its advantages, the “asset drop down” model is not a perfect solution for all situations. First, it can result in phantom gain in certain transactions in which only some physician owners are selling their interest and

others are not or in which physicians are selling different amounts of their ownership and such amounts are not pro rata based on ownership. In other words, under the “asset drop down” model, the S-corporation is the entity selling an interest in Newco. As a result, the purchase price proceeds will be paid to the S-corporation. Under applicable S-corporation tax laws, the S-corporation’s taxable gain from the sale is allocated for tax purposes pro rata among all of the owners based on their respective ownership percentages, even though the money may only be paid to one owner or a small group of owners who are cashing out or to the owners in a non-pro rata amount.

There is probably no better way to build up resentment among the remaining physician utilizers than by forcing them to owe taxes to the Internal Revenue Service (IRS) on money they did not actually receive. One business strategy to consider addressing this matter is to cause the S-corporation to make a distribution of a portion of the purchase price proceeds to cover a portion or all of each owner’s taxes with the balance paid to those owners cashing out.

Second, the result of an “asset drop down” transaction is that Newco will have a different tax identification number than the S-corporation. A new tax identification number likely means that Newco must obtain new licenses, as well as contract with and register the new tax identification number with the ASC’s commercial payers. This can often cause a meaningful interruption in the ASC’s cash flow as the ASC obtains such third-party consents. The S-corporation also may need to obtain various other third-party approvals (e.g., landlord, lender, etc.) for the transfer of its assets to Newco.

[D] Development Agreements and Management Agreements

When an ASC management company or health system is involved in the development of an ASC or acquires an equity interest in an ASC, the ASC typically enters into a development agreement (if the ASC is a start-up) and/or a management agreement (for an existing ASC). Such agreements provide for the development/management company to provide a variety of administrative services.

One rationale for retaining a management company is that it enables the physician owners to focus on delivering the highest quality of patient care without having to worry about the day-to-day administrative issues. Management companies also often bring to the table solid management experience, the benefit of greater bargaining power with managed care companies, and cost efficiencies through group purchasing.

To minimize the risk that the management arrangement will violate the federal anti-kickback statute, the parties may want to consider structuring the management agreement to fit within the personal services and management contracts safe harbor. To do so, the management agreement must be in writing, and the aggregate management fee must be set in advance, consistent with fair market value in exchange for actual, necessary services to the ASC, for a term of at least one year, and the arrangement must be commercially reasonable. Most

importantly, the management fee must not take into consideration the volume or value of referrals generated between the parties. As a result, the safest fee structure from a regulatory perspective is a fixed fee over the term of the management arrangement.

That, however, is not common in practice. It is more likely that the management fee is structured as a percentage of the ASC's revenues, net collections, or other form of variable compensation. Such fee arrangements will not qualify under the personal services and management contract safe harbor. Nonetheless, such fees arguably do not raise material risk under the anti-kickback statute, primarily because the ASC management company is not a source of referrals (unless it engages in marketing activities designed to generate patients for the ASC).

One issue often overlooked is whether the management fee must be at least fair market value. If the fee is below fair market value, then a regulator could argue that the manager is providing services at a discount in order to induce the physicians to utilize the ASC of which the manager is also an owner. Notwithstanding this concern, some management companies do not charge a fee for their management services. To the extent the management company does not charge a management fee, the parties should carefully consider the legal implications of such an arrangement.

As discussed above, failing to charge a management fee could implicate certain regulatory concerns. Nonetheless, physician owners of ASCs are increasingly questioning the justification for a management fee. Some ASCs view the fee as simply another revenue source for the management company and that the management company is not delivering any additional value for such fees. This is reminiscent of the physician practice management era when doctors were selling their practices to practice management companies for significant multiples but shortly thereafter questioned the lack of management services being delivered.

To address these concerns, an ASC may attempt to negotiate a cap on a percentage-based management fee and incorporate certain performance benchmarks by which the management company will be measured (e.g., 80 percent of accounts receivable will be collected within a certain period of time). By closely reviewing the management agreement to ensure that the management company will be held accountable for the services it promises to deliver, a good management company can truly add value to an ASC and develop a trusting relationship with its physician owners.

Another concern to be mindful of in management arrangements are state fee-splitting prohibitions. These laws generally prohibit health care providers from engaging in any split-fee or division-of-fees arrangement with another individual or entity with respect to the health care provider's professional fees in exchange for patient referrals for health care services. These prohibitions, where applicable, vary by state and may cover all categories of health care services or be limited to certain designated health services.

§ 5.06 DUE DILIGENCE IN ASC EQUITY TRANSACTIONS

[A] Due Diligence

Prior to acquiring an equity interest in an ASC, a buyer typically will undertake some form of due diligence of the ASC. In practice, the scope of such due diligence often is limited by the amount of time and money that the buyer is willing to spend. That, in turn, likely will be impacted by the investor's existing knowledge of and involvement with the investment, the size of the investment, and the investor's tolerance for risk.

Of course, any investment in an ASC requires at least a rudimentary level of due diligence. For example, an ASC investor should always review the financial statements of the ASC to determine the ASC's profitability, existing debt, and other key financial data. Moreover, an investor should confirm whether the ASC is subject to any creditor, tax, or judgment liens. It also is important to perform a search of any criminal, licensure, or board disciplinary actions as well as any malpractice suits with respect to the ASC and the physicians who utilize the ASC.

From a health care regulatory perspective, there are three additional areas of diligence that are critical and should not be overlooked. First, a potential investor may want to consider examining any financial relationships between the ASC and its referring physicians. Such relationships could arise in a variety of settings, including medical director agreements, space or equipment lease arrangements, and ancillary ventures including those related to anesthesia, clinical laboratory services, or medical imaging.

Second, a potential investor often will conduct a thorough examination of the ASC's billing and collection practices. Such diligence should include a billing audit by reviewing a sampling of the ASC's Medicare claims and third-party payer claims over a one-to-three-year period for any improper billing practices. Additionally, it is important to include a review of the ASC's payer contracts to confirm whether the ASC is required to notify or receive the approval of the payer before consummating the transaction. Some ASCs heavily rely on out-of-network billing, and many others have a policy of waiving patient copayments. Both of these practices can create some concerns.⁵⁶ While even the most successful ASC likely has some out-of-network billing component, such practices are becoming increasingly scrutinized by third-party payers. A routine practice of waiving copayments can also create issues under state insurance laws.

Third, it is critical for an investor to gain comfort that the ASC has been operating in compliance with health care regulatory laws. Assuming the ASC is billing Medicare, Medicaid, or other governmental reimbursement programs, it is important to confirm whether the ASC has been operating in accordance with the

⁵⁶ See Jerry J. Sokol, Esq., *Legal Update—Out-of-Network Billing: Lucrative but Risky*, *Outpatient Surgery Magazine* (Jan. 2004).

conditions of participation for such programs. In that regard, an ASC could be subject to a regulatory investigation or disciplinary action, including a corporate integrity agreement (CIA). Investing in such an ASC may not necessarily be a poor investment depending on the purchase price, but it is important to fully understand the reason and scope of the investigation or any limitations imposed on the ASC's continued operations as a result of the CIA. The OIG recently announced that it intends to increase unannounced site visits and enforcement efforts against providers subject to CIAs.⁵⁷ Thus, purchasing an interest in an ASC subject to a CIA is not something that should be taken without adequate due diligence.

It should be emphasized that the above discussion regarding the scope of an ASC investor's due diligence investigation is by no means exhaustive. Legal counsel and financial advisors experienced in corporate and health care regulatory due diligence should be consulted.

A buyer typically will commence its due diligence prior to having any obligation to invest. For example, the buyer and seller may have entered into initial discussions or even executed a letter of intent or term sheet. At such point, the buyer, however, is likely not yet obligated to acquire an interest in the ASC. As a result, an ASC should consider requiring the buyer to enter into a confidentiality agreement to protect the sensitive information provided to the potential buyer for purposes of conducting the due diligence investigation and to protect the existence of the potential transaction. Typically, such a confidentiality agreement will require the buyer to acknowledge that the buyer has received proprietary information regarding the ASC's structure, operations, agreements, and financial statements and will ask the buyer to agree not to disclose any of such information. Information publicly known is typically excluded from such restrictions.

[B] Medicare, Certificate of Need, and State Licensure Issues

[1] Medicare

In connection with the sale or purchase of an interest in an ASC, a CMS Form 855-B will need to be completed and filed with the Medicare carrier. To the extent the ASC's employer identification number does not change, the transaction likely will be treated as a change of information from a Medicare perspective. By contrast, if the ASC's employer identification number will change (such as in an asset purchase), Medicare will consider the transaction to be a change of ownership (CHOW). While the distinctions between a change of information and a CHOW are beyond the scope of this chapter, a change of information is generally easier to effectuate and subject to less scrutiny.

⁵⁷ See *OIG Shifting to Unannounced Site Visits to Assess CIA Compliance, Adherence*, BNA Health Care Daily Report, Vol. 12, No. 80 (Apr. 26, 2007).

[2] Certificate of Need

The certificate of need (CON) process is a state's method of monitoring the number of health care facilities or services being provided in a given geographical area.⁵⁸ CON states allow government control and regulation over the entry of new health care providers, facilities, and equipment into the market by matching the demand for health services with the supply. Each CON state has its own list of the types of facilities that require a CON prior to being established.⁵⁹ A CON is not the same as the state ASC license.

Typically, a CON is not transferable to a new owner. A CON application generally will require detailed information about the ASC's owners, and states typically require notification upon any change in the ownership information provided. The definition of a CHOW varies by state. In some states, a CHOW occurs only if all (or substantially all) of the assets of the surgery center have been sold and where the new owner of the ASC will have a new federal tax identification number. In other states, the sale of a certain percentage threshold of the equity in an ASC (e.g., more than 50 percent) could trigger a CHOW.

[3] Licensure Issues

The licensure requirements of an ASC can be divided into the following three categories: (1) federal licenses or permits, (2) state licenses or permits, and (3) local county and city licenses and permits. At the federal level, an ASC should hold a controlled substances registration issued by the federal U.S. Drug Enforcement Administration (DEA). Sometimes one or more individual physician owners may personally hold such controlled substances registration in lieu of the ASC. In such instances, a buyer should be cautious of whether the physician holding such registration will be departing the ASC in the near future. Due to those concerns, a buyer typically will want the ASC to hold its own DEA registration. To the extent the ASC holds the DEA registration, a new DEA number is required whenever the CHOW involves a sale of more than 50 percent of the ownership interests of the ASC.

If any laboratory testing is performed at the ASC, the ASC should be registered with CMS' program under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). CLIA makes a distinction between holding a permit for non-waived testing versus holding a certificate of waiver if the provider is only performing waived testing. Many ASCs only perform waived tests (e.g.,

⁵⁸ In some states, this is referred to as a certificate of public need, certificate of public review, or determination of need.

⁵⁹ ASCs are subject to a CON or similar need certificate in the following states: Alabama, Delaware, Georgia, Mississippi, South Carolina, North Carolina, Tennessee, Kentucky, Virginia, West Virginia, Washington DC,

Maryland, New York, Vermont, New Hampshire, Maine, Massachusetts, Connecticut, Rhode Island, Illinois, Iowa, Montana, Nevada, Washington, Michigan, Alaska, and Hawaii. For a 50-state survey of ASC CON laws, see Robert James Cimasi, *The U.S. Healthcare Certificate of Need Sourcebook* (Beard Publishers 2005).

blood glucose monitoring) and thus hold a certificate of waiver rather than a CLIA license. A review of the applicable CLIA regulations should be undertaken to confirm whether the ASC is engaging in waived or non-waived testing and whether any notice or approvals will be needed in connection with same.

With respect to state licensure, an ASC typically is required to be licensed by the state's Department of Health or other applicable government agency, unless an exception applies. Such licensure requirement likely applies irrespective of whether a separate CON is required as well. Generally, the licensure process involves the submission of an application, along with an application fee, satisfaction of certain criteria, and depending on how the transaction is structured as well as the applicable state's laws, an onsite survey to ensure that the state licensure criteria has been met. An ASC's state license typically is not transferable. Thus, if an existing ASC is undergoing a CHOW, a new ASC license is often required. What constitutes a CHOW and the CHOW process depends on the laws of the state in which the ASC is located.

ASCs often are required to maintain a host of other state licenses and permits such as a state pharmacy license, radioactive materials permit, and laboratory permit. Various licenses and permits also may be needed at the county or city level, including a bio-hazardous waste permit and occupational license. The CHOW process for these "ancillary" state and local licenses often is overlooked. Failure to comply with such laws could result in hefty penalties and the potential suspension of the ASC's operating license. This matter can be further exacerbated by the fact that each license in the same state could be subject to different definitions of what constitutes a CHOW and the process that should be followed in connection with a CHOW. This can be particularly important since a condition to an ASC's participation in the Medicare program is that the ASC operate in compliance with the applicable state's laws.⁶⁰ Accordingly, there is always the potential exposure that failing to hold all of the appropriate state licenses and permits could result in the suspension or revocation of the ASC's participation in the Medicare program.

§ 5.07 CONCLUSION

As ASCs continue to gain in popularity, there likely will continue to be an increase in ASC equity transactions. These transactions raise a variety of business and legal issues that should be addressed prior to and during the consummation of a transaction. To those in the market of selling or buying interests in ASCs, it is essential to understand and appreciate these issues.

⁶⁰ See 42 C.F.R. § 416.40 *et seq.* for Medicare conditions for coverage of an ambulatory surgical center.