Seal The Deal: Health Care Mergers And Acquisitions In Pennsylvania

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ABSTRACT

The health care industry is in the throes of dramatic change, prompted in part by the Obama administration's signature legislation, the Patient Protection and Affordable Care Act (the "ACA"). In an effort to improve quality and contain costs, among other things, the ACA seeks to encourage greater coordination and integration across the health care continuum. The health care industry is reacting in part by consolidation—mergers and acquisitions aimed at increasing horizontal and vertical integration. Given the fact that the health care industry is so heavily regulated at the federal and state levels, various regulatory and business law issues must be considered and hurdles must be overcome in completing these transactions. This article provides an overview of some of the principal health care regulatory and business law issues that can arise in merger and acquisition transactions in Pennsylvania, including oversight by the Attorney General's office and the Orphans' Court; regulatory approvals from the Medicare program, state Department of Health and other agencies; antitrust considerations; the corporate practice of medicine doctrine and the fiduciary duties of directors and officers.

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ATTORNEY GENERAL AND ORPHANS' COURT REVIEW OF NON-PROFIT TRANSACTIONS

Background

Under Pennsylvania law, the assets of a charitable nonprofit corporation must be dedicated to charitable purposes. Prior to any fundamental change that results in any diversion of the assets from that charitable purpose, a court must determine that the disposition of the property also furthers a charitable purpose.[1] At least one Pennsylvania court has held that all of the properties of a charitable nonprofit corporation are held in trust as charitable assets, and therefore, court review is required in connection with any fundamental transaction, such as the sale of all or substantially all of the nonprofit corporation's assets.[2] The Pennsylvania nonprofit corporation law ("NCL") also provides that future interests in gifts to a nonprofit corporation that has sold its assets are effective only pursuant to an order from a court having jurisdiction over the assets.[3]

AG Review Protocol

Deal counsel must consider a host of regulatory and business law issues that often impact health care mergers and acquisitions in Pennsylvania.

In the wake of the bankruptcy of AHERF, which had grown rapidly in the 1990s through numerous acquisitions of hospitals in Pittsburgh and Philadelphia, in 1997 the Pennsylvania Office of Attorney General ("OAG") developed a "Review Protocol for Fundamental Change Transactions." The Review Protocol applies "[w]henever a nonprofit, charitable health care entity enters into a transaction effecting a fundamental corporate change which involves a transfer of ownership or control of charitable assets."[4]

According to the OAG, the Review Protocol applies regardless of the form of the transaction contemplated (*i.e.*, sale, merger, consolidation, lease, option, conveyance, exchange, transfer, joint venture, affiliation, management agreement or collaboration arrangement, or other method of disposition) as well as regardless of whether the transaction parties are nonprofit, mutual benefit, or for-profit entities.[5] Transactions occurring in the usual and regular course of the nonprofit's activities, however, are not subject to the Review Protocol.

For transactions subject to the Review Protocol, parties are required to furnish at least ninety days' notice to the OAG prior to the date of its consummation. The OAG instructs parties to submit extensive and specific documentation as part of that notice.[6]

The OAG's review of the transaction is quite broad in scope. The Review Protocol states that OAG's review will include, "among other components," information gathering, review of fiduciary responsibilities of directors (particularly relative to the exercise of due diligence, the assessment of self-dealing and whether or not the transaction is at arm's length), fair market valuation analysis, inurement inquiry, public interest review to evaluate the transaction's effect upon the availability and accessibility of health care in the affected community as well as appropriate *cy pres* determination. The Review Protocol states that the OAG may engage experts and consultants to assist in the review, with the costs borne by the transaction parties.[7]

OAG typically conducts a public hearing and invites members of the public to comment on the proposed transaction pursuant to the Review Protocol. Members of the public generally also have the ability to submit comments and information to OAG separate from the public hearing.

According to the Review Protocol, upon completing its review, the OAG may "issue a letter indicating that it has no objection to the transaction; bring judicial proceedings

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[1] 15 Pa.C.S.A. §§5530(a), 5547(b). If the charitable purpose is not being fulfilled, the court may, under certain circumstances, "order an administration or distribution of the estate for a charitable purpose in a manner as nearly as possible to fulfill the intention of the conveyor" pursuant to the *cy pres* doctrine. 20 Pa.C.S.A. §6110.

[2] *In re Roxborough Memorial Hospital*, 17 Fiduc. Rep. 2d 423 (1997).

[3] 15 Pa.C.S.A. §5550.

[4] Pennsylvania Attorney General, Review Protocol for Fundamental Change Transactions Affecting Health Care Nonprofits," *available at* http://www.attorneygeneral.gov/consumers.aspx?id=229 (last visited Feb. 22, 2014).

[5] *Id.*

[6] *Id.*

[7] *Id.*

to enjoin consummation of any disputed transaction; seek to void any transaction consummated . . . ; or take any other action it deems appropriate."[8]

Orphans' Court

Orphans' Court review is typically initiated by the filing of a petition by the nonprofit corporation involved in the transaction. Examples of relief sought in past petitions include court approval of the transaction, a determination that the transaction does not involve a diversion of charitable assets, a ruling with respect to future interests, a *cy pres* ruling with respect to the use of the proceeds by a foundation, and relief from deed restrictions on transferred property.

The Orphans' Court has jurisdiction over the disposition of assets of a nonprofit corporation.[9] The Orphans' Court will hear matters involving the administration and proper application of property committed to charitable purposes held or controlled by any domestic or foreign nonprofit corporation and questions of law pertaining to the affairs of such entities.[10]

Transaction parties are often concerned that a third party will seek to intervene in the Orphans' Court process to disrupt the transaction, even if OAG does not object to the sale. Generally, the only persons who may participate in such proceedings are the Attorney General, a member of the charitable organization or someone having a special interest.[11] Private parties typically lack standing to participate in proceedings involving charitable organizations.[12]

Often, parties ask whether there is any risk in closing the transaction immediately after the Orphans' Court issues an order approving the transaction. An order, decree or adjudication from the Orphans' Court is subject to an exceptions period and an appeals period. Because failure to file exceptions to an order, decree or adjudication is not a waiver of grounds for appeal, a party may forgo filing exceptions and still file an appeal within thirty days.[13] Transaction parties often wait at least until expiration of the twenty-day exceptions period, if not the full thirty-day appeal period, before closing.

Practitioners should be mindful of the following issues, which are among those that the OAG and Orphans' Court have consistently identified as relevant to their review of nonprofit health care transactions:

- A Board's robust decision-making process, evidenced by thorough evaluation of available options and/or reliance upon third-party advisors (*e.g.*, consultants and attorneys), is helpful towards making OAG and the Orphans' Court comfortable with the transaction.
- The absence of conflicts of interest by participating officers, board members and advisors is critical to the integrity of the decision-making process.
- It can be relevant whether the purchase price is consistent with the fair market value of the assets being transferred, as demonstrated by an independent third-party valuation, a competitive bidding process or otherwise.
- Whether the seller is likely to be able to continue to operate the facility absent the proposed transaction can be a threshold issue in a transaction involving the sale of a distressed facility.
- Special post-closing contractual commitments are often included in the purchase agreement, which are aimed at assuring that the buyer will fulfill certain elements of the seller's historical mission (e.g., continuation of indigent care policies).

Oversight of transactions involving nonprofit and health care institutions is subject to state-specific laws and procedures.[14] In contrast to the Pennsylvania process described above, the New Jersey Community Health Care Assets Protection Act, for example, estab-

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[8] *Id.*

[9] 20 Pa.C.S.A. §711(21).

[10] 31 Pa.B. 3186.

[11] *Valley Forge Historical Society* v. *Washington Memorial Chapel*, 426 A.2d 1123, 1127 (Pa. 1981) (citing *Wiegand* v. *Barnes Foundation*, 97 A.2d 81, 82 (Pa. 1953)).

[12] *See In re Milton Hershey School*, 911 A.2d 1258, 1262 (Pa. 2006) (citing *In re Pruner's Estate*, 136 A.2d 107, 109 (Pa. 1957) (holding that the alumni association, comprised of former students of the charitable Milton Hershey School, lacked standing to challenge the rescission of an agreement between the Attorney General and the Milton Hershey School Trust, which funded the school); *see also In re Barnes Foundation*, 2004 WL 1960204, at *10 (Pa. Com. Pl. Montgomery Cty. 2004).

[13] *See* Pa. O.C.R. 7.1.

[14] The National Association of Attorneys General has developed model legislation on conversion of nonprofit health care entities to for-profit status

lishes a process for attorney general and licensing agency review and court approval for an array of "acquisitions" of New Jersey hospitals by nonprofit or for-profit entities.[15]

REGULATORY APPROVALS (FEDERAL AND STATE)

Medicare

Classification of the Transaction

Generally, a transaction involving a Medicare provider can be classified as alternatively involving a change of ownership ("CHOW"), requiring a new Medicare enrollment, or having no impact on the provider's continued Medicare enrollment. The principal guidance on whether a transaction constitutes a CHOW is set forth in Medicare regulations at 42 C.F.R. §489.18 and the *Medicare State Operations Manual* ("SOM"), Chapter 3, §§3210 *et seq*.

The sale of the assets of a health care provider to a new entity that will continue to operate the provider constitutes a CHOW unless the new owner rejects assignment of the Medicare provider agreement. The merger of a corporation owning a Medicare provider into another corporation (*i.e*., the corporation owning the Medicare provider is not the surviving corporation) or the consolidation with another corporation resulting in the creation of a new corporation constitutes a CHOW. However, the merger of another corporation into the corporation owning the Medicare provider (*i.e*., the corporation owning the Medicare provider is the surviving corporation) does not constitute a CHOW.

The sale or transfer of stock of a corporation owning a Medicare provider (even 100% of the stock) does not constitute a CHOW. The removal, addition, or substitution of a partner constitutes a CHOW, unless the partners expressly agree otherwise, as permitted by applicable state law.

Medicare regulations state that the lease of all or part of a provider facility constitutes a CHOW of the leased portion. This presumes that the lessee will be responsible for the operations of the provider entity.

If an entity that owns a Medicare provider enters into a management agreement with another party, it does not constitute a CHOW if the owner retains general approval of operating decisions, "even though the management firm may appear to have wide latitude in making decisions, and even though its fee may be based on the net revenue or profit the facility receives from furnishing service."[16]

A new Medicare enrollment is involved if the Medicare provider enrollment is not or cannot be transferred to the new owner, or if, in the case of transaction that would otherwise constitute a CHOW, the new owner rejects assignment of the provider agreement. If the transaction does not require new enrollment and does not constitute a CHOW, the Medicare provider's enrollment continues unaffected by the transaction.

Regulatory Process

The regulatory process that the buyer and seller must follow, and the consequences of the transaction for Medicare purposes, differ depending on how the transaction is classified. Within thirty days of the effective date of the change, the buyer and seller must report a CHOW by completing the relevant sections and submitting a Medicare enrollment application on Form CMS-855A or B.[17]

In the case of a CHOW, "the new owner is subject to all the terms and conditions under which the existing agreement was issued," including implementing any plans of correction, deficiencies, civil rights requirements, Medicare sanctions and penalties. Courts have held that, in the context of a CHOW, the new owner is responsible for the Medicare overpayment liabilities and the civil money penalty liabilities of the seller.[18] Generally, a CHOW does not require a new survey of the facility.

A CMS-855A CHOW application is reviewed by the fiscal intermediary, which makes a recommendation to the state survey agency, which then reviews and submits its recommenda-

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[15] N.J.S.A. 26:2H-7.10 *et seq.*

[16] CMS, *Medicare State Operations Manual*, CMS Pub. 100-07, Chapter 3, §3210.1D.5, *available at* http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984.html (last visited Feb. 22, 2014).

[17] 42 C.F.R. §424.516. CMS-855A CHOW applications may be accepted by the intermediary up to 90 calendar days prior to the anticipated date of the proposed ownership change, but any application received more than 3 months in advance of the projected sale date can be returned. Medicare Program Integrity Manual, Chapter 10, §5.5.2.3.F.

[18] *U.S.* v. *Vernon Home Health, Inc.*, 21 F.3d. 693 (5th Cir.), *cert. denied*, 513 U.S. 1015 (1994)); *Deerbrook Pavilion, LLC* v. *Shalala*, 235 F.3d 1100 (8th Cir. 2000).

tions to the CMS regional office. The CMS regional office makes a final determination as to the acceptance of the CHOW. Upon acceptance, the CMS regional office issues a "tie-in notice."

In the case of a CHOW, CMS will not send payments to the new owner until the tie-in notice is issued.[19] Instead, the contractor continues to pay the old owner until it receives the tie-in notice from the regional office.[20]

In order to reject automatic assignment in the case of a transaction that would otherwise be a CHOW, the new owner must notify the CMS regional office in writing 45 calendar days prior to the closing of the transaction.[21] The new owner would have to complete a Medicare enrollment application on Form CMS-855A or B. As a result of a new enrollment, the new owner will not inherit the attributes associated with the prior owner's provider number. In such a case, there may be negative attributes (*e.g.*, a troublesome compliance history or potential overpayments) or positive attributes (*e.g.*, Medicare FTE caps needed for GME reimbursement, or grandfathered status for certain providers) to which the new owner will not succeed.

In the case of a transaction classified as a new enrollment, the new owner "will not be able to participate in the Medicare program without going through the same process as any new provider, *i.e.*, enrolling with the FI, applying for participation, undergoing Office of Civil Rights ("OCR") clearance and an initial survey, having an effective date of participation assigned based upon regulation, etc."[22] The new owner will not be entitled to Medicare reimbursement for services furnished prior to completion of the survey.

Medicare does not make new enrollment easy. The SOM provides that the subsequent survey of the new applicant must be performed after the CHOW and after the fiscal intermediary recommends the applicant for approval to CMS in accordance with current procedures.[23] Recent CMS guidance further discourages buyers to reject automatic assignment of the seller's Medicare provider number by ensuring that such buyers face greater delay enrolling in and securing the ability to bill Medicare.[24] Perhaps not surprisingly, acquirers of Medicare providers have very rarely rejected automatic assignment of the seller's provider number.

Even though a transaction does not involve a CHOW or new enrollment, the provider may be required to report changes to its existing enrollment data resulting from the transaction. For providers and suppliers other than physicians, nonphysician practitioners, and their organizations, such a change of information must be reported within thirty days for a "change of ownership or control" or within ninety days for "[a]ll other changes to enrollment."[25]

Pennsylvania Licensed Health Care Facilities

Certain types of health care facilities and providers are licensed by the Pennsylvania Department of Health ("DOH") under the Pennsylvania Health Care Facilities Act, 35 P.S. §448.801 *et seq*. These include hospitals, home health agencies, home care agencies, hospices, long-term care nursing facilities, cancer treatment centers using radiation therapy on an ambulatory basis, ambulatory surgical facilities, and birth centers.

The Pennsylvania Health Care Facilities Act provides that a health care provider must meet certain requirements to receive a license. These include, for example, that the health care provider is a "responsible person," that the health care provider has achieved "substantial compliance" with applicable rules and regulations adopted by the DOH and that, if necessary, a certificate of need has been issued.[26] A central concern in connection with DOH's review of a transaction is whether the acquiring entity is a "responsible person."

DOH requires written notice from licensed health care facilities in advance of certain transactions. For example, parties must provide thirty days' notice to the DOH for a transfer involving 5% or more of the stock or equity of a health care facility or a change in ownership (*i.e.*, transferring the controlling interest in a health care facility), the form of ownership or the facility name.[27] Changing the person responsible for the day-to-day operation of the health

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[19] CMS, *Medicare Program Integrity Manual*, CMS Pub. 100-08, Chapter 10, §6.1.2, *available at* http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019033.html (last visited Feb. 22, 2014).

[20] *Medicare Program Integrity Manual*, Chapter 10, §5.5.2.5.

[21] *Medicare State Operations Manual*, Chapter 3, §3210.5A.

[22] *Medicare State Operations Manual*, Chapter 3, §3210.

[23] *Medicare State Operations Manual, Chapter* 3, §3210.5A.

[24] *See* CMS Policy Memorandum 13-60-All, posted September 6, 2013.

[25] 42 C.F.R. §424.516.

[26] 35 P.S. §448.808(a).

[27] 28 Pa. Code §§51.4(a)-(b).

care facility also requires thirty days' notice to the DOH.[28] Hospitals are required to "advise the Department no later than ninety days prior to an intended change of ownership or control of the hospital."[29] DOH restricts the transfer of a hospital license to the new owner until the agency determines it is a "responsible person."[30]

Questions can arise whether a transaction involves a "change of ownership" of the facility requiring submission of a licensure application and related materials. An example of such a situation may be the public offering of stock of an entity several rungs up the corporate ladder from the licensed entity that owns and operates the health care facility. In such a case, it is advisable to work with DOH to determine how the transaction will be treated and what information DOH may require.

Following notice of change of ownership of a health care facility, a packet of change of ownership documents must be submitted to the appropriate division within DOH. In the case of a hospital change of ownership, the following materials must be submitted:

- Hospital Licensure Application;
- Hospital/CAH Medicare Database Worksheet (used to collect information about a hospital's services, locations, and staffing);
- DOH "Information Requested of Health Care Providers Applying for a License to Operate a Health Care Facility" (reviewed by DOH Office of Chief Counsel);[31]
- Password Agreement (to enable electronic access to statements of deficiency and plans of correction);
- Medicare Provider Agreement;
- U.S. DHHS Civil Rights Information Request for Medicare Certification;
- U.S. DHHS Assurance of Compliance document;
- PA DOH purchaser acknowledgement concerning Noncompliance with State and Federal Regulations (*i.e.*, that the purchaser is responsible to correct pre-acquisition deficiencies);
- Staff Assurances document (providing assurances to DOH as to the background and qualifications of key administrative staff members); and
- License fee.

In recent years, interested parties have sometimes sought to utilize DOH's oversight of health care facilities to attempt to interfere with or influence the review of transactions involving licensed health care facilities. In at least one case, interested parties sought formally to inject themselves in DOH's licensure review process, which ultimately led to a judicial decision addressing the licensure process.[32] The case involved the 2007 acquisition of stock of Manor Care, Inc., which owned numerous licensed skilled nursing facilities in Pennsylvania and other states, by the Carlyle Group, a private equity firm. Residents of two facilities sought to intervene in DOH's review of the CHOW licensure applications under the Pennsylvania Administrative Agency Law and related regulations. The DOH refused to allow the petitioners to intervene and, on appeal, the Commonwealth Court issued a holding that severely limited the nursing home residents' right to intervene in the licensure process under the Health Care Facilities Act.[33]

Pennsylvania Medical Assistance

A change in ownership or control interest of 5% or more of a provider enrolled in the Medical Assistance program must be reported to the Department of Public Welfare ("DPW") within thirty days of the date the change occurs. Failure to submit a complete and accurate report constitutes a deceptive practice under section 1407(a)(1) of the Public Welfare Code (62 P.S. §1407(a)(1)) and justifies a termination of the provider agreement by the Department.[34] In addition to the general provisions, DPW regulations require specific notice to the DPW of a change of ownership of a nursing facility (including submission of a copy of the sales agreement). The failure to comply with such general and specific notice requirements results in the provider forfeiting all reimbursement for nursing care services for each day the notice is overdue.[35]

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[28] 28 Pa. Code §51.4(c).

[29] 28 Pa. Code §101.52.

[30] 28 Pa. Code §101.52.

[31] *Available at* http://www.portal.state.pa.us/portal/server.pt/community/nursing_home_care/14152/information_requested_of_health_care_providers_applying_for_a_license_to_operate_a_health_care_facility/558476 (last visited Feb. 22, 2014).

[32] *Adams* v. *Department of Health*, 967 A.2d 1082 (Cmwlth Ct. 2009).

[33] *Id*. at 1089 (footnote omitted).

[34] 55 Pa. Code §1101.43(b)(1).

[35] 55 Pa. Code §1101.43(b)(2).

The buyer or seller submits a notice letter describing the transaction and stating the closing date. DPW will likely require the buyer to file additional information in response to its letter. Assuming a CHOW determination is made, the buyer will be required to reenroll in the program (with new provider numbers to be assigned). Applications are to be submitted once Medicare provider tie-in notice has been issued.

Other State Agencies

Other types of health care facilities and health care services are licensed by other state agencies or under other authorities. These include (but are not limited to):

Agency	Facility or Service
Department of Health	Clinical Lab Permit
	CLIA Waiver
Department of Public Welfare	Adult day care center
	Child day care center
	Family day care home, Boarding home for children
	Mental health establishment
	Personal care home
	Assisted living residence
	Psychiatric hospitals and units
Insurance Department	Continuing Care Retirement Community
Department of Aging	Adult Day Program
State Board of Pharmacy	Pharmacy Permit
	Air Quality Program Operating Permit
	Certificates of Registration, Radiation Producing Machines
	Certificate of Acknowledgement Medical/ Non-Medical Accelerator
Department of Environmental Protection	Radioactive Materials License

ANTITRUST

Background

Antitrust issues may arise in different types of health care transactions and can directly impact hospitals, physicians, Accountable Care Organizations ("ACOs"), payors, pharmaceutical manufacturers and suppliers. Providers need to be mindful of antitrust risk as hospitals and physicians pursue strategies toward greater alignment and consolidation.

Principal Antitrust Laws and Key Antitrust Guidance

The principal antitrust laws are Sections 1 and 2 of the Sherman Act and Section 7 of the Clayton Act, and much of the key guidance relevant to health care (discussed below) has been issued pursuant to these statutory provisions. In addition, depending on the size of the transaction and the parties involved, pre-merger notification to the Federal Trade Commission ("FTC") and the Department of Justice ("DOJ") may be required under the Hart-Scott-Rodino Antitrust Improvements ("HSR") Act. Premerger notification enables regulators to review the anticompetitive effects of proposed transactions.

Issued in 1996 by FTC and DOJ, "Statements of Antitrust Enforcement Policy in Health Care" sets forth the agencies' antitrust enforcement policies regarding mergers and various joint activities in the health care area.[36] The guidance addresses mergers among hospitals, joint purchasing arrangements among health care providers, physician network joint ventures, multiprovider networks, and more.

Since 2002, the FTC has issued a series of advisory opinions analyzing whether networks of independent providers may collectively contract with payors without violating antitrust laws because the network's collaborative efforts will enhance patient care and create effi-

[36] *Available at* http://www.justice.gov/atr/public/guidelines/0000.htm (last visited Feb. 22, 2014).

ciencies.[37] On February 13, 2013, the FTC issued the Norman PHO Advisory Opinion, its first guidance for a clinically integrated network since the passage of the Affordable Care Act.[38] It suggests that the FTC will review clinical integration proposals favorably, provided that networks impose safeguards to prevent anticompetitive effects.

In 2010, FTC and DOJ issued revised horizontal merger guidelines, which outline analytical techniques, practices, and enforcement policies the agencies use to evaluate mergers and acquisitions involving competitors.[39] The 2010 guidelines are not specific to the health care industry and, like transactions in any industry, will apply to hospital mergers that are outside of the safety zone.

In 2011, FTC and DOJ issued a joint policy statement outlining the agencies' antitrust enforcement strategy with respect to ACOs.[40]

Application of Antitrust Guidance to Network Formation

Significant antitrust problems can arise where competing physicians enter into network agreements with hospitals to jointly negotiate with managed care organizations. Such conduct, particularly within the context of physician hospital organizations ("PHOs"), may constitute impermissible price-fixing agreements as well as improper exercises of physician market power through physician participation in the PHO.

FTC and DOJ have often permitted providers to come together to jointly negotiate with managed care organizations without triggering per se review (under Section 1 of the Sherman Act) provided that the providers demonstrated that they were financially integrated (*e.g.*, furnishing services under capitation arrangements).

Networks lacking financial integration have sidestepped horizontal price-fixing problems and ensured antitrust compliance by employing messenger model PHOs. Under this arrangement, the network serves merely as a conduit that transmits offers, counteroffers, and contracting decisions between payors and provider-members. All competing providers unilaterally decide what prices they will individually accept from the payor.[41]

Antitrust problems may also emerge as providers shift toward clinical integration as a means to improve quality and efficiency. Generally, clinical integration involves providers collaborating to furnish higher quality patient care in a more efficient manner. Ironically, antitrust considerations arise when the clinically integrated network (often a joint venture comprised of participating competing physicians and hospitals) jointly negotiates with payors to achieve the procompetitive efficiencies for the clinical integration to succeed. Nevertheless, the FTC and DOJ recognize that clinical integration "may produce efficiency benefits that justify joint pricing."[42] Accordingly, both agencies consider clinical integration when reviewing whether providers may jointly negotiate with managed care organizations. As noted above, the FTC has issued favorable advisory opinions where the proponents can show a level of integration and collaboration that enhances quality and efficiency.

Pennsylvania Antitrust Issues

Although Pennsylvania has not enacted its own comprehensive antitrust laws, the Pennsylvania OAG also reviews health care transactions from an antitrust perspective. In some transactions, OAG has resolved antitrust concerns by obtaining commitments addressing the conduct going forward (rather than seeking to prevent or unwind a transaction). Examples include planned merger of Shamokin Area Community Hospital into Geisinger Medical Center,[43] and the merger of a group of urologists in the Harrisburg area.[44]

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[37] *See e.g.*, FTC Staff Advisory Opinion to Greater Rochester Independent Practice Association, Inc., September 17, 2007, *available at* http://www.ftc.gov/sites/default/files/documents/advisory-opinions/greater-rochester-independent-practice-association-inc./gripa.pdf (last visited Feb. 22, 2014).

[38] *See* Norman PHO Advisory Opinion, February 13, 2013, *available at* http://www.ftc.gov/os/2013/02/130213normanphoadvltr.pdf (last visited Feb. 15, 2014).

[39] http://www.ftc.gov/os/2010/08/100819hmg.pdf.

[40] Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, Issued by the DOJ and the FTC (October 2011), *available at*: http://www.justice.gov/atr/public/health_care/276458.pdf (last visited Feb. 5, 2014).

[41] *See* Statements of Antitrust Enforcement Policy in Health Care, Statement 9; *see also*, FTC Staff Advisory Opinion to Bay Area Preferred Physicians (September 23, 2003), *available at* http://www.ftc.gov/bc/adops/bapp030923.shtm (providing guidance concerning the structure of messenger organizations).

[42] Statements of Antitrust Enforcement Policy in Health Care, Statement 9.

[43] *Commonwealth of Pennsylvania* v. *Geisinger Medical Center Shamokin Area Community Hospital*, No. 344 MD 2011 (Cmwlth Ct. 2011); *Commonwealth of Pennsylvania* v. *Geisinger Health System Foundation et al.*, Civil Action No. 4:12-cv-01081 (MD Pa 2012).

CORPORATE PRACTICE OF MEDICINE ISSUES

Physician involvement in health care transactions can trigger issues under the corporate practice of medicine doctrine, which generally prohibits physicians from providing physician services on behalf of, or in concert with, any entity not authorized to provide professional services. Counsel should review these laws in connection with certain transactions (*e.g.*, physician practice acquisitions and joint ventures involving professional services between physicians and providers or other unlicensed entities).

Many unanswered questions continue to surround the corporate practice of medicine in Pennsylvania. Pennsylvania's corporate practice of medicine doctrine is rooted in the Pennsylvania Supreme Court's decision in *Neill* v. *Gimbel Brothers, Inc.*, 199 A. 178 (1938), which has not been overruled or modified in the 75 years since the original holding. Subsequent case law is sparse and other authorities provide limited guidance. Not surprisingly, this uncertainty creates challenges because relevant authorities and recognized exceptions are limited, and fail to account for new health care delivery models, such as those being developed in response to the ACA.

Similar to many state statutes, the Pennsylvania Medical Practice Act only allows licensed individuals to practice medicine.[45] Nevertheless, if applicable requirements are satisfied, under various authorities, Pennsylvania authorizes certain entities to employ physicians and/or to provide professional services. These entities include professional corporations, nonprofit corporations, health care facilities and their affiliates, HMOs and restricted professional companies.

Because of the corporate practice of medicine doctrine, non-physician investors desiring to offer physician services (alone or with other services) often set up two entities—a professional corporation that employs physicians through which physician services are furnished (often referred to as a "captive PC" or "friendly PC"), and a management company that, under contract with the professional corporation, furnishes all non-physician services to the business (*e.g.*, space, equipment, non-physician staffing, billing and collection, and other functions). Two recent cases applying Pennsylvania law caution about the structure of these arrangements.[46]

FIDUCIARY DUTIES OF BOARDS AND EXECUTIVES

Duty of Care

In the case of health care disposition transactions, the duty of care is best discharged by a thoughtful and careful process that demonstrates due diligence and inquiry. Factors that could be relevant include the financial and other circumstances of the nonprofit corporation that led to the consideration of the transaction, the consideration of alternatives, the criteria used to evaluate the alternatives, the purchase price and other terms of the transaction, and the evaluation of whether the transaction is in the public interest.

Duty of Loyalty

In the case of health care disposition transactions, the duty of loyalty requires particular attention be given to potential conflicts of interest. A director or officer may have a conflict of interest, for example, if he/she is a physician whose practice may be affected by the transaction, is a vendor to the facility subject to the transaction, has an investment interest in the buyer, or has a retention agreement with the nonprofit corporation. Conflicts need to be disclosed and appropriately dealt with. Directors also must not disclose confidential information of the corporation, such as the existence and terms of a potential transaction.

OTHER ISSUES/CONSIDERATIONS

RTKL Issues

The Pennsylvania Right to Know Law ("RTKL") gives the public the right to access the records of state agencies, subject only to limited exceptions.[47] State agency records that are subject to disclosure under the RTKL include documents submitted to the agencies. In gen-

[44] *Commonwealth of Pennsylvania* v. *Urology of Central Pennsylvania, Inc. et al.*, Civil Action No. 1:11-cv-01625-JEJ (MD Pa 2011).

[45] 63 P.S. §422.10.

[46] *Apollon* v. *OCA*, 592 F.Supp. 2d 906 (E.D. La. 2008); *OCA* v. *Hodges*, 615 F.Supp. 2d 477 (E.D. La. 2009).

[47] 65 P.S. §67.101 *et seq*.

eral, information submitted to a state agency as part of a licensure application is regarded as public records. Nevertheless, certain information such as personal identification information or trade secret or confidential proprietary information may be covered by an exception to the RTKL. To best protect such information from public disclosure under the RTKL, licensure applicants and other parties furnishing information to state agencies should consider including a written statement or legend appropriately identifying such information as not subject to disclosure under the RTKL.

Kickback/Self-Referral Issues

Depending on the parties to a transaction, a health care transaction can raise issues under the federal Anti-Kickback Statute and the Ethics in Patient Referrals ("Stark") Law. While a full discussion of these issues is beyond the scope of this article, practitioners should be mindful, in particular, that payments that deviate from fair market value and payments involving an "earn out" can be problematic under these laws.

Tax Exempt Organizations

A hospital can qualify as a charitable organization under Section 501(c)(3) of the Internal Revenue Code. 501(c)(3) organizations are subject to restrictions that can affect their transactions with third parties, including sales transactions.

Conferring more than incidental private benefit to a Section 501(c)(3) organization can result in its loss of tax exempt status. The sale of a hospital to a for-profit corporation for a price less than fair market value can result in impermissible private benefit.

No part of the net earnings of a section 501(c)(3) organization may inure to the benefit of any private shareholder or individual (often referred to as "insiders"). Any private inurement can result in the loss of the organization's tax-exempt status. Transactions involving a 501(c)(3) organization with insiders must be reasonable and fair to the exempt organization.

Section 4958 of the Internal Revenue Code imposes significant excise taxes on excess benefit transactions between a tax-exempt organization and a disqualified person. Under certain circumstances, conversion transactions can lead to intermediate sanctions.[48]

Due Diligence

Often, a buyer will conduct significant regulatory due diligence concerning a target health care provider, including confirming that all necessary licenses and permits have been obtained and are in good standing, review of past licensure and accreditation surveys of the facility, consideration of compliance with Medicare conditions of participation and other applicable regulations, review of any governmental investigations or inquiries, examination of transactions with other parties (such as physicians) that could raise fraud and abuse concerns.

Representations and Warranties/Indemnification

An acquisition agreement will typically not only contain general representations as to compliance with laws, but also include specific representation from the seller concerning its adherence to specific regulatory requirements that are material to the facility.

CONCLUSION

Health care mergers and acquisitions, driven in part by the ACA and other health reform initiatives, present a host of issues and challenges that are seldom seen in business transactions involving less heavily regulated industries. In this regard, this article is a survey of certain licensing, reimbursement, regulatory and professional standards issues typically at play in health care transactions. Because these deals often bring to bear so many different areas of the law, practitioners are advised to develop a framework for identifying and working through these and other issues in these deals. Of course, new regulations that could affect health care mergers and acquisitions are constantly emerging, and counsel should also keep abreast of state and Federal regulatory developments that may impact deals in the industry.

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[48] *See e.g., Caracci* v. *Commissioner of Internal Revenue*, 456 F.3d 444 (5th Cir. 2006).