Davis Wright Tremaine LLP

Building Capacity

Legal Strategies for Hospital Growth in a Constrained Market

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Agenda

Background	The capacity problem: bed and occupancy data, workforce, reimbursement, and the regulatory overlay
Buy It	Transaction targets and structures, distressed hospitals, approvals and timing, site-neutral risk, where deals go wrong
Build It	Build options, approvals and reimbursement, financing the build, hospital at home and virtual care
Partner for It	Joint ventures, affiliations and transfer networks, leasing and managing units
Repurpose and Optimize It	Service line conversions, value-based care, conversion checklist
Key Takeaways	Summary points

Program Focus for Lawyers

This program examines the legal and regulatory frameworks governing hospital capacity expansion strategies, including:

- Transaction structuring
- Healthcare regulatory approvals
- Fraud and abuse compliance
- Antitrust scrutiny
- Reimbursement risk
- Provider enrollment

Legal and Regulatory Constraints on Capacity Expansion

- Hospitals need more capacity, but
  - New beds are slow and expensive
  - Workforce shortages limit operational expansion
  - Reimbursement does not consistently support growth
  - Regulators are scrutinizing consolidation
  - Seismic mandates compete for capital
  - Payers working to shift care to outpatient spaces (reimbursement structure, use of prior authorizations, medical necessity reviews)

Legal and Regulatory Constraints on Capacity Expansion

- Every capacity strategy is ultimately a tradeoff among:
  - Speed
  - Capital
  - Workforce
  - Regulatory burden
  - Reimbursement stability

Counsel's Role: Guiding Capacity Decisions for Compliance with Laws and Enrollment and Reimbursement Requirements

- **Pressure Test the Initiative:**
  - What is a great idea in every other context is often illegal in healthcare
  - Are there fraud and abuse considerations? Referral source issues?
  - Are their scope of practice issues?
  - Are there antitrust issues?
  - Has the OIG weighed in on novel arrangements?
- **Own the Regulatory Critical Pathway**
  - Identify the filings and timeline
  - Identify any reimbursement gap or delay
  - Track laws that could change filing requirements or initiative's structure

Counsel's Role: Guiding Capacity Decisions for Compliance with Laws and Enrollment and Reimbursement Requirements

- **Assemble the specialist team early:** Antitrust, tax-exempt, real estate/CEQA, labor, reimbursement, coding and billing experts
- **Review enrollment and reimbursement items**
  - Review payer contracts for anti-assignment and change of control provisions
  - Confirm arrangement meets Medicare and Medicaid requirements for reimbursement
- **Build Compliance Record**
  - Bring in compliance team early to review arrangement
  - Keep a file for the arrangement documenting fair market value, commercial reasonableness, signed agreements, as applicable

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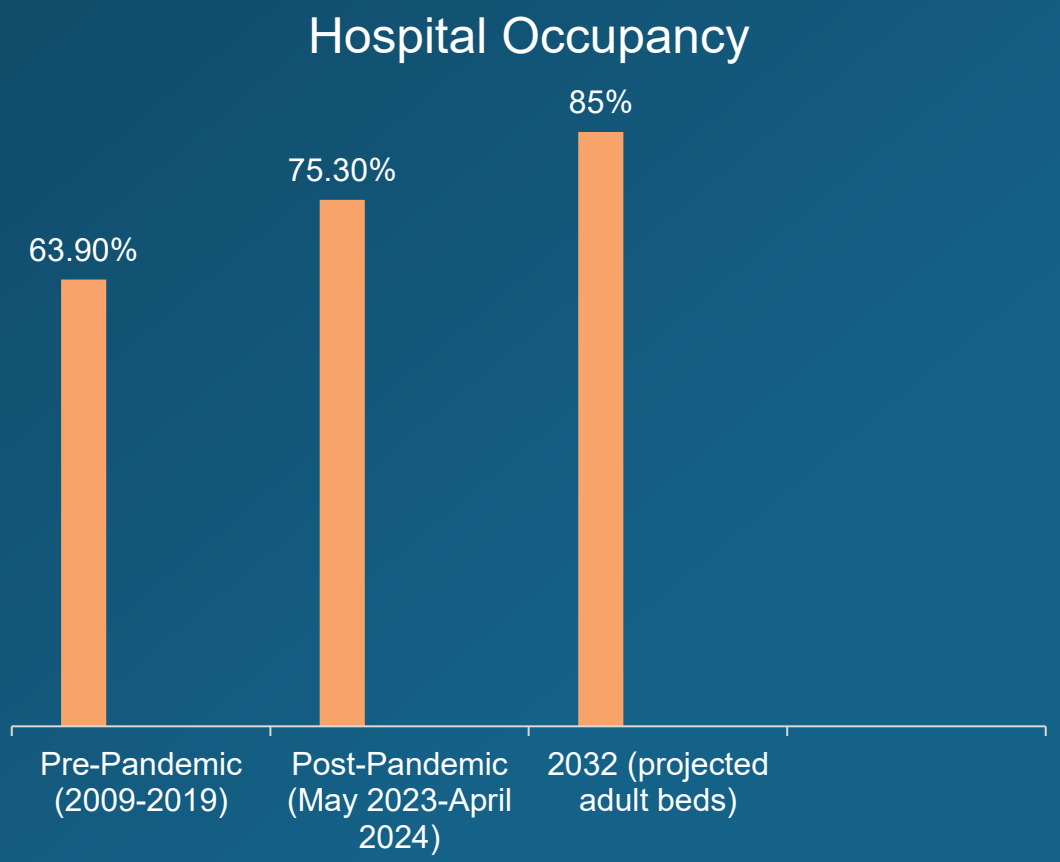
[The authors of one study] begin to quantify the story already felt at the bedside in hospitals across the nation—namely, a trajectory toward inadequate supply of hospital care for the anticipated demand of the coming decade.

Janke et al.

JAMA Network Open (2025), “Understanding and Addressing the US Hospital Bed Shortage-Build, Baby, Build.”

Capacity Issues

- Experts generally view a national hospital occupancy of 85% as a hospital bed shortage
  - Insufficient buffer against daily turn over, seasonal fluctuations in hospitalizations, or unexpected surges



Leuchter et al., *JAMA Netw Open* (Feb. 19, 2025).

Capacity Issues

- Staffed hospital beds
  - Pre-pandemic (2009-2019): 802,000
  - Post-pandemic: 674,000
    - 16% reduction in hospital beds



Capacity Issues

- Severe healthcare workforce shortages
  - Existing RN shortage, significantly accelerated by the pandemic
  - Post-pandemic provider burnout among all types of clinicians
- ED patient load
  - Non-urgent visits to cover gaps in primary care
- Aging population
  - High acuity
  - Longer stays
- Post-pandemic hospital closures
  - Increased supply costs
  - Increase staffing costs
  - Payer mix challenges
  - Reimbursement challenges
  - Aging infrastructure
- Private equity transactions can result in scaled back or restructured inpatient capacity

Four Ways to Add Capacity

Buy It	Build It	Partner For It	Repurpose and Optimize It
• Acquire new capacity	• New hospitals, towers, new facilities	• JVs, affiliations, leases, payer and public partnerships	• Service line conversion, investment in outpatient and telehealth

Each pathway trades off speed, capital, regulatory burden, and risk

Healthcare Laws Overlay

- Capacity strategies may implicate:
  - State level reviews
    - Pre-transaction filings (CON, state-specific review such as or Attorney General in California)
    - Land use review
  - State licensure
  - Medicare and Medicaid enrollment changes
  - Private payor contracting
  - FTC/DOJ antitrust review
  - Stark Law / AKS
  - Provider-based billing rules
  - Labor and union obligations
- The regulatory timeline often determines the operational timeline.

Questions to Ask Before Choosing a Strategy

- Is the constraint on beds, staffing, reimbursement, or throughput?
- Is the need temporary or structural?
- Is speed more important than control?
- Can the organization absorb regulatory delay?
- Is capital available?
- What is the payer mix?
- What capacity already exists in the market?
- Will physicians support the strategy?
- Will the community / patient population support the strategy?
- Is seismic investment already required?
- **Will the solution actually address the problem?**

Buy It



Buy It: Counsel's Core Legal Questions

- Is the transaction reportable under HSR or state mini-HSR laws?
- Does the structure create successor liability risk?
- Can Medicare provider agreements be assigned?
- Are there change-of-control payer contract restrictions?
- What approvals are conditions precedent to closing?
- What reimbursement assumptions require legal validation?
- What diligence findings trigger disclosure obligations?

Transaction Targets and Associated Legal Issues

Acute Care Hospitals

Adds: inpatient beds, ORs, ED, licensed service lines

Watch: CHOW and Medicare provider agreement assignment; CON; AG review (nonprofit); FTC merger scrutiny; EMTALA and survey history

Physician Practices

Adds: clinicians, referral base, specialty coverage

Watch: corporate practice of medicine; Stark/AKS fair market value comp; noncompetes; serial-deal antitrust and state notice laws

Ambulatory Surgery Centers

Adds: lower-cost surgical capacity as procedures shift outpatient

Watch: physician-owner syndication and safe harbors; ASC CON in some states; FTC divestiture risk

Post-Acute Providers

SNF, IRF, LTACH, home health, hospice

Adds: discharge throughput, frees acute beds

Watch: CHOW and 36-month rule (home health/hospice); state licensure; staffing and survey exposure

Outpatient & Ancillary Sites

Imaging, urgent care, freestanding EDs (not in CA), labs

Adds: access points and diagnostic capacity

Watch: provider-based vs. freestanding status and site-neutral payment; Stark in-office ancillary exception (pre-closing diligence, post-closing structural considerations)

Behavioral Health

Inpatient psych, outpatient therapy, psychiatry

Adds: relief for ED boarding; unmet demand

Watch: state licensure, payer credentialing, IMD exclusion (expanding facility past 16 beds can change Medicaid eligibility)

Transaction Structures and Associated Legal Issues

Asset Purchase

True Change of Ownership

Pros: buyer picks assets and leaves most past liabilities behind

Watch: CHOW filings; accepting the Medicare provider agreement brings past liabilities; contracts must be assigned

Stock / Equity Purchase

Buyer acquires the target entity itself

Pros: licenses, contracts, and provider numbers often stay in place

Watch: all historical liabilities come along; change-of-control consents; regulatory filings (some agencies still view this as a CHOW)

Merger

Two entities combine; one survives

Pros: full integration

Watch: State approvals, full successor liability, integration issues

Member Substitution

Nonprofit version of a stock deal

Pros: fewer approvals, often less disruptive

Watch: AG / charitable-asset review; reserved powers; not available in every state; regulatory filings (some agencies still view this as a CHOW)

Joint Venture

Entity co-owned by system and partner (e.g., ASC, behavioral health)

Pros: shares capital and expertise; less than full control

Watch: AKS/Stark for physician investors; governance; tax-exempt status

MSO / Friendly PC

For physician practices in corporate practice of medicine states

Pros: buyer runs the business side through a management agreement

Watch: CPOM limits on control; fair market value management fees; new state scrutiny of MSOs

Transaction Structures: Short of an Acquisition

LOOSER ALIGNMENT → CLOSER INTEGRATION / MORE CONTROL

Clinical Affiliation

Shared protocols, recruitment, transfers, branding

Adds: specialty access and expertise; low cost to exit

Watch: AKS for anything of value exchanged; covenants often "soft"; antitrust if rivals share data

Physician Alignment

Professional services agreements; service line co-management

Adds: physician capacity and service-line leadership

Watch: Stark/AKS fair market value; wRVU compensation design; no pay tied to referrals

Management Agreement

Bring in manager to run the hospital or a department; owner keeps control

Adds: management skill and scale (manager may help hospital use the capacity it already has)

Watch: tax-exempt bond private use (Rev. Proc. 2017-13); fee structure

Whole-Hospital Lease

Lessee operates the facility for a long term. Adds capacity by near acquisition of a new facility for its system.

Adds: near-acquisition control without buying the real estate

Watch: Regulatory filings; bond private use; licensure

Transaction Structures: Distressed Hospital Acquisitions

POTENTIAL ADVANTAGES

- Faster market entry
- Existing licensure and infrastructure
- Existing contracts and referral patterns
- Reduced purchase price

HIDDEN RISKS

- Deferred maintenance
- Seismic liabilities
- Pension obligations
- Cultural instability
- Weak payer mix
- Staffing shortages
- Community opposition
- Pressure to finance to get to closing
- Risk of bankruptcy
- Bankruptcy can add a layer of complexity but can help address liabilities
- New operator doesn't necessarily resolve operational challenges

Health Law Transaction Considerations

- Pre-closing filings and approvals
  - Timeline
  - Surveys
  - Temporary approvals
  - Scrutiny of PE-backed ventures
- Gaps in reimbursement and operations
  - Transition services agreements
  - Interim management agreements
  - Medicare CHOW can be 3-9+ months
  - Medicaid may be longer
- Changes in reimbursement
  - Public hospital versus private
- Contract assignment / contract rates



Site-Neutral Payments Change Expansion Economics

WHERE IT HITS

Areas of exposure

— Off-campus HOPDs
— Acquired physician clinics
— Outpatient migration strategies

WHY IT MATTERS

Strategic risks

— Lower reimbursement
— Reduced margin assumptions
— Payer adoption beyond Medicare
— Long-term uncertainty in outpatient investment models

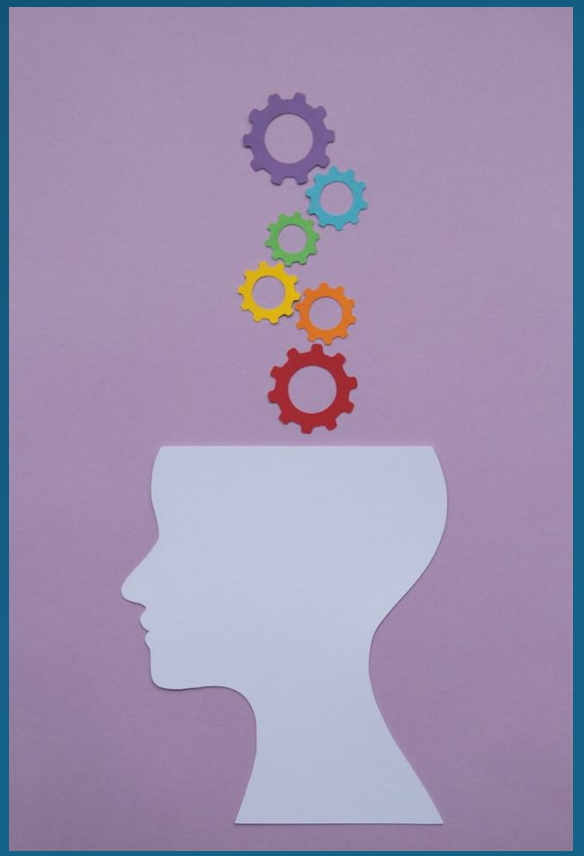
PRACTICAL TIP

Stress-test the model

Model reimbursement under multiple future payment scenarios before acquisition.

Will the New Acquisition Address Capacity Constraints?

- Realistic expectations about reimbursement (run the numbers)
  - Changes to ownership might impact reimbursement
  - Ability to assume contracts or expand existing contracts to acquired facility
  - Site neutral payments
  - Constraints on 340B
- Patient population / payer mix
- Why is the seller selling?
  - Will the same issues survive the transaction?
- Staffing issues
  - Unions
  - Culture considerations
- Will patients use the new facility?



Where Deals Go Wrong: Legal Edition

OPERATIONAL

- Late diligence findings
- Overestimating available workforce
- Underestimating integration costs
- Assuming payer contracts transfer automatically
- Missed notice obligations
- Delayed regulatory approvals

FINANCIAL

- Unrealistic reimbursement assumptions
- Failure to model site-neutral payment risk
- Ignoring seismic or deferred maintenance costs
- Underestimating impact of transaction on timing of post-closing reimbursement

GOVERNANCE

- JV deadlock
- Misaligned incentives
- Unclear exit rights

Buy It: Purchase Agreement

PRE-SIGNING

- Privileged diligence protocol and reporting lines
- Clean team agreements for competitively sensitive data (payer rates, wages)
- No gun-jumping before HSR and state waiting periods expire
- Calendar state notices
- Diligence known overpayments, CIAs, open surveys, and self-disclosures

AGREEMENT TERMS

- Healthcare compliance reps: Stark/AKS, billing, licensure, HIPAA
- Special indemnity for pre-closing Medicare/Medicaid overpayments and recoupments
- Escrow or holdback sized to CHOW and cost report exposure
- R&W insurance: expect billing and coding exclusions
- Interim operating covenants on service lines, staffing, and payer contracts

CLOSING & BEYOND

- Closing conditions tied to CHOW, licensure, and AG approval
- Transition services and cost report allocation
- Tail coverage for professional liability and D&O
- Survival periods aligned with False Claims Act look-back (up to 10 years)
- Compliance plan for AG conditions (often multi-year service commitments)

Build It

“If you build it, [they] will come.”



Build It: Counsel's Core Legal Questions

- What state approvals are required?
- Is a CON required?
- Are provider-based billing requirements achievable?
- What reimbursement assumptions depend on regulatory status?
- Are there tax-exempt financing restrictions?
- What construction risks require contractual allocation?
- Are there CEQA or land use litigation risks?
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Legal Structures for Capacity Expansion

- New hospital
- New hospital tower
- HOPD
- ASC
- Freestanding ED (not in California)
- Micro-hospital (not in California)



Approvals & Reimbursement

- Analyze expected reimbursement for new build while planning
- Model reimbursement under site-neutral scenarios before committing capital
  - Consider provider-based rules
- State approvals, as applicable
  - CON
  - Facility plan review and construction oversight
- Local land use and CEQA review
- Licensure for new beds and services

Financing the Build

- Tax-exempt bonds: Private use limits
- Sale-leasebacks and REITs: Liquidity vs. long-term rent risk
- Public-private partnerships (P3s)
- Physician/system JVs: Stark and AKS structuring
- Construction contracting: Delivery method, risk allocation, delays



Build It: Counsel's Document Checklist

- **Construction contracts**
  - Delivery method (design-bid-build, design-build, CM at-risk, IPD) drives risk allocation
  - Plan review and inspection delays: schedule, change order, and delay-claim provisions
  - Liquidated damages, consequential damages waivers, insurance, and bonding
- **Financing documents**
  - Tax-exempt bonds: private business use review of management, lease, and research agreements in financed space
  - Sale-leasebacks: rent escalators, master lease covenants, and default remedies
- **Physician investment: offering documents, AKS safe harbor analysis, FMV support**
- **Entitlements: build CEQA litigation risk into the critical path**

Beyond Brick and Mortar: Other Builds

- Hospital at home / CMS Acute Hospital Care at Home waiver (not allowed in all states)
  - Capacity Without Building Beds
  - Potential Benefits
    - Lower capital investment
    - Reduced ED boarding / increased throughput
    - Right care in right setting
    - Patient preference alignment
  - Legal & Operational Issues
    - CMS waiver extended through September 2030 (but no guarantee of extension)
    - State licensure and scope of practice
    - EMTALA implications
    - Technology and monitoring
    - Reimbursement sustainability

Beyond Brick and Mortar: Other Builds



Virtual Nursing



Tele-ICU



Telehealth Programs

Partner for It



DWT.COM

Partner for It: Counsel's Core Legal Questions

- Does the arrangement implicate Stark or AKS?
- Is there antitrust risk from competitor collaboration?
- How should governance rights be structured?
- What exit mechanisms protect against regulatory change?
- Does physician ownership fit within safe harbors/exceptions?
- Are there tax-exemption/private benefit concerns

JV Targets & Considerations

- Targets: Rehab, behavioral health, ASCs, imaging, post-acute
- Considerations:
  - Antitrust
  - Fraud and abuse considerations with physician involvement
  - Negotiation of board composition and reserved powers
  - Deadlock resolution mechanisms
  - Exit rights (draft the exit before the entrance!)
    - Buy-sell
    - Puts and calls
    - Valuation methods
  - Unwinding plans for regulatory change

Leasing & Managing Units

- Leasing or managing units within another hospital
- Hospital-within-hospital requirements
- Provider-based rules and co-location guidance
  - Co-location is permitted with clear space, staffing, and time delineation and documentation.
- FMV rent and management fees; AKS lease safe harbor

Partner for It: JV and Lease Documents

JV AGREEMENT

- Reserved powers and supermajority matters
- Deadlock: escalation, mediation, buy-sell triggers
- Regulatory unwind clause for changes in law
- Capital calls and dilution
- Distributions pro rata to capital, never tied to referrals

FRAUD, ABUSE & TAX

- Test investment terms against AKS safe harbors
- FMV and commercial reasonableness opinions
- Map each physician arrangement to a Stark exception
- Tax-exempt partners: control to protect exempt status (Rev. Rul. 98-15)
- Noncompetes: Cal. Bus. & Prof. Code § 16600 limits

LEASES & MANAGEMENT

- Written, signed, term of at least one year, compensation set in advance
- Hospital-within-hospital separateness documentation
- Provider-based attestations
- Termination and transition of licensed beds
- Centralized contract database for Stark compliance

Repurpose & Optimize It



Repurpose & Optimize It: Counsel's Core Legal Questions

- Are notices or hearings required?
- Will service reductions trigger state review?
- What labor obligations apply?
- How does EMTALA affect transitions?
- Will reimbursement change after conversion?
- Are existing licensure categories compatible with the new use?
- Are there community benefit implications?

Conversion Options

- Inpatient to outpatient
  - Additional ambulatory offerings to capture more patients, take pressure off of the ED
  - Movement of care to lower-acuity settings (e.g., ASCs)
- Outpatient to virtual
  - Increased telehealth options
- Inpatient to behavioral health
- Acute to SNF, rehab, or psych
- Crisis stabilization and sobering centers
- Swing beds and observation units
- Bed reclassification and temporary bed increases
- Alternate care sites
- Service line closures and reallocation of space
  - Hard look at unprofitable service lines
  - Assess how to repurpose that space

Conversion Options: Value-Based Care

- Building capacity by rethinking how care is delivered.
- Consider whether value-based care supports conversions / shifts in care delivery
  - Hospitals can consider investing / enhancing multidisciplinary care teams, data systems, digital tools, patient navigators and programs that help manage chronic and complex conditions.
  - These programs can help identify patients who need additional support, improve transitions between care settings, and reduce unnecessary variation in care.
  - Value-based care, in turn, may reward hospitals for quality of care and cost efficiency so that reimbursement supports the shifts in how care is offered.

Conversion Options: Look Before You Leap

- Reimbursement implications (really run the numbers beyond “back of the napkin” calculations)
  - Contracting implications
  - Does a shift to value-based care support the conversion strategy or support reimbursement
- Licensing process, notice requirements, CON, where applicable
  - Licensing requirements may differ from existing service line
- Gaps in reimbursement during conversion
- Staffing requirements
  - Intersection with unions

Conversion Options: Look Before You Leap

- Pay attention to related requirements (e.g., trauma level requirements, existing AG conditions)
- Pay attention to required notices
- Community benefit and Schedule H reporting
- Medical staff bylaws and union effects bargaining
- Continuity of care and reputational management

Repurpose & Optimize: Legal Risk

- **Service reductions and closures**
- **Labor: effects bargaining; federal WARN and Cal-WARN notice for layoffs**
- **EMTALA and patient abandonment risk during transitions**
- **Medical staff: privileges and bylaws hearing rights when departments close**
- **Community opposition: build a record that can withstand challenge**

Key Takeaways

Key Themes

- Capacity constraints are operational, financial, and regulatory—not just physical
- Workforce shortages affect every strategy
- Reimbursement assumptions should be stress-tested early
- Regulatory review increasingly drives transaction timelines
- The fastest solution is often optimizing existing assets
- Most systems will need a blended strategy

Comparison Matrix: Four Strategies

Strategy	Speed to Capacity	Capital Cost	Regulatory Burden	Risk Profile
Buy It	Moderate; months of antitrust, AG, review	High	**High:** HSR/FTC, State transaction reviews; CHOW filings	Inherited liabilities, integration
Build It	Slowest; multiyear	Highest	**High:** State approvals, licensure, regulatory filings	Construction, financing, site-neutral payments
Partner for It	Moderate to fast	Shared / moderate	**Moderate:** Stark/AKS, antitrust	Governance, deadlock, exit
Repurpose & Optimize	Fastest	Low to moderate	**Variable:** licensure, notice/hearing	Workforce, community, reputation

Lawyer's Role: Sequencing Approvals & Documentation

- Map every approval on one critical-path timeline
- **Sequence:** Antitrust and state transaction approvals, then licensure/CHOW regulatory filings, Medicare filings
- Board minutes reflecting deliberation, alternatives, and charitable purpose
- Community benefit narrative supporting the strategy

Thought Exercise

The Distressed Community Hospital

- A nonprofit system considers acquiring a financially distressed community hospital
  - Aging infrastructure with seismic needs
  - Significant ED demand
  - Weak commercial payer mix
  - Persistent staffing shortages
  - Challenging collective bargaining agreements

Thought Exercise: The Lawyer's Questions

- Does the acquisition actually solve the capacity problem?
- What approvals drive timing?
- What liabilities are being inherited?
- How does reimbursement change post-transaction?
- What workforce strategy is required?
- How will the nonprofit turn things around?

Questions?

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