HOSPITAL/PHYSICIAN JOINT VENTURES: IF YOU CAN'T BEAT THEM, JOINT VENTURE WITH THEM

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The relationship between hospitals and physicians has historically been very close and mutually beneficial. In recent years, however, reductions in reimbursement, changes in technology, and other dynamics in the health care industry have put hospitals and physicians in a much more adversarial position. As they seek ways to increase their incomes, physicians have begun directly competing with hospitals for lucrative service lines like outpatient surgery and imaging services. This increased competition between hospitals and physicians has led to disputes that have been evidenced in certificate of need battles and the development of conflict of interest credentialing policies by some hospitals.

Rather than use valuable resources to fund these disputes with physicians, many hospitals are looking at more opportunities to work with certain members of the medical staff in developing certain services. While these joint ventures may make strategic and economic sense, hospitals and physicians need to examine the various compliance issues that apply to hospital/physician relationships to ensure that any type of venture is on sound legal ground. These compliance issues, which involve the federal Stark, Anti-Kickback, tax exempt laws and state self-referral and anti-kickback laws, are often the driving force to establish a particular structure for these joint ventures.

There are many types of structures that are available to hospitals and physicians when they consider working together more closely. This spectrum highlights some of these structures based on the preferred level of hospital/physician integration.

Spectrum of Hospital/Physician Joint Ventures

Low Integration Potential Low Risk, Low Return			High Integration Potential High Risk, High Return			
Service/ Management Agreements • Medical Director Agreements • Exclusive Agreements • Call Coverage Arrangements	Garnishing Arrangements • Specific to particular service line or DRG • Limited time frame	Leasing Models • CV Diagnostic Center • Imaging Center	Service Line Management Model • Orthopedics Service Line • Certain Clinical and Economic Control Given to MDs	IP/OP JV Models • PHOs • Specialty Hospitals	Service Line Under Arrangements Outsourcing • IP/OP Service Lines • Service Line Center of Excellence	Integrated Delivery System • Hospital Employed MDs • Whole Hospital JV

Many hospitals are familiar with the use of professional service agreements and medical director agreements to obtain needed services and to involve the physicians in strategic projects. Also, more and more hospitals are evaluating the employment of physicians, including the development of hospital-owned physician networks. Recently, we have also seen hospital/physician ventures such as management agreements or the use of "under arrangement" structures becoming more popular.

In an "under arrangements" joint venture model, generally the hospital and physicians contract for the management and operation of certain services offered by the hospital. For example, the physicians may be engaged to manage and operate certain services in the hospital's outpatient surgery department. A services agreement is entered into between the hospital and physicians, under which compensation to the physicians might be a periodic fixed fee, a "per click" usage, or perhaps a percentage of collections methodology.

For Medicare purposes, the term "under arrangements" is an arrangement whereby (a) a hospital engages a third party to perform hospital services on behalf of the hospital; (b) the services remain hospital services, billable to Medicare by the hospital; and (c) receipt of Medicare payments by the hospital discharges the liability of the Medicare beneficiary or any other person to pay for the services. For outpatient services delivered "under arrangements," the hospital is able to be paid for services under the Ambulatory Payment Classification ("APC") of the outpatient prospective payment system. As a condition to the hospital receiving payments for services performed "under arrangements" the hospital must exercise certain control over the provision of services and must include the "under arrangements" services in its utilization review, quality assurance, and peer review activities. There are additional provider-based regulations to comply with to allow services preformed by a third party on behalf of a hospital to be reimbursed under the APC.

Similar to the "under arrangements" concept, a hospital could enter into a services agreement with physicians for the management of a particular department. Under this arrangement, the physicians would bill and collect for the professional services and the hospital would bill and collect for the technical component of the services. Alternatively, a hospital could lease all of its operations. Generally these arrangements are long-term and the agreements contain certain control and oversight provisions for the hospital.

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Provider Self-Referral laws. If the hospital is tax-exempt under Section 501(c)(3) of the Internal Revenue Code, there are also federal tax laws to consider. If the hospital is a governmental entity, then there are South Carolina constitutional issues to consider.

The federal Stark law is a civil law that prohibits physicians from referring patients for designated health services ("DHS") to an entity with which the physician has a financial relationship for which payment may be made under Medicare. DHS include (1) clinical lab services; (2) physical therapy services; (3) occupational therapy services; (4) radiology or other diagnostic services; (5) radiation therapy; (6) durable medical equipment; (7) parenteral and enteral nutrients, equipment and supplies; (8) prosthetics, orthotics and prosthetic devices; (9) home health services; (10) outpatient prescription drugs; and (11) inpatient and outpatient hospital services.

Under Stark, if a physician has a financial relationship with an entity that is providing DHS, then the physician may not make a referral to the entity for DHS if the entity intends to make a claim to Medicare for the DHS unless the relationship comes within a statutory or regulatory exception. The sanctions for violations of Stark include possible refund of Medicare reimbursement attributable to services billed in violation of Stark and civil penalties of no more than $15,000 for each service for which Medicare payment was sought. Additionally, the provisions of the Civil Monetary Penalty Statute apply, which allow for triple damages for the government, and the provider may be excluded from Medicare and Medicaid. Therefore, the joint venture arrangement must be structured to fit within an exception to Stark. There are numerous statutory and regulatory exceptions to Stark. It is critical that hospitals and physicians understand how to comply, and maintain compliance, with the exception applicable to their arrangement.

The Anti-Kickback Statute is a federal criminal statute which prohibits a person from knowingly and willingly soliciting or receiving any remuneration in return for referring an individual for medical care paid by Medicare or Medicaid. A person who violates the statute is guilty of a felony and upon conviction may be fined up to $25,000 and/or imprisoned up to five years, and may be excluded from participation in the Medicare and Medicaid programs. Additionally, civil monetary penalties may apply.

Similar to exceptions to Stark, the Anti-Kickback regulations outline certain common commercial arrangements that are deemed not to violate the statute if certain requirements are met (the "Safe Harbors"). However, unlike Stark, which requires compliance with an exception to avoid a violation of Stark, the failure to qualify under a Safe Harbor does not mean that the arrangement is a per se violation of the Anti-Kickback statute.

The cornerstone to meeting almost every Stark exception and Anti-Kickback Safe Harbor is that the compensation under the arrangement be fair market value. Documenting fair market value is a necessity in any potential joint venture.

In 2003, the OIG released a Special Advisory Bulletin regarding contractual joint ventures, outlining specific concerns. For example, joint ventures that in essence turn an existing business or arrangement into a joint venture solely to flow dollars to physicians would be suspect to the OIG. It is important that the physicians contribute something to the arrangement, such as money, business expertise or assumption of business risk. Potential joint ventures need to establish a justifiable business reason for the joint venture such as, increasing quality patient access to health care services.

The South Carolina Provider Self-Referral Act prohibits certain referrals of "designated health services," which is more broadly defined than under Stark, by a provider to entities in which they have an investment interest. There are also provisions similar to the federal Anti-Kickback statute in the Act. A joint venture arrangement can generally be structured to fit within an exception to the Act, similar to the Stark exception. Unlike the Stark law, the Act only applies to an investment or ownership interest. There has not been much guidance as to the interpretation of the language in the Act, although recent Advisory Opinions from the South Carolina Department of Labor, Licensing and Regulation has raised questions regarding the use of one or more often relied upon exceptions under the Act that deals with work that is personally performed, directed, or supervised by the physician who has ownership interest and makes a self referral.

If the hospital is tax-exempt under Section 501(c)(3) of the Internal Revenue Code and has tax-exempt bond financed facilities, any management or lease arrangement must comply with the private business use rules. These rules severely limit the use of tax-exempt bond facilities by private parties. It is extremely important to have any arrangement analyzed under these rules to ensure that the bonds maintain their tax-exempt status. Otherwise, bond holders may be surprised to learn that the interest on the bonds is taxable, and the hospital may be liable to the bondholders based upon representations and warranties of the hospital in the bond documents.

Additionally, if the physicians participating in the joint venture arrangement are "insiders" or "disqualified persons" under federal tax law, such as Board Members or individuals with influence over the organization, then there are additional considerations to be certain the hospital maintains its tax-exempt status and the physicians are not subject to any excise tax under the federal tax laws.

Further, there is much guidance to review from the Internal Revenue Service regarding particular joint venture structures and how an arrangement should be structured to protect the hospital's tax-exempt status by ensuring certain control and oversight by the hospital over the joint venture. Additionally, the compensation under the arrangement should be reviewed to ensure that the arrangement could not be construed as a sale of a revenue stream of the hospital.

If the hospital is a governmental entity these arrangements are subject to the South Carolina Constitution, which states that "neither the State nor any of its political subdivisions shall become a joint owner of or stockholder in any company, association, or corporation." This constitutional prohibition is generally an obstacle to government hospitals' participation in traditional equity joint ventures, but other contractual joint ventures may be structured to comply with this constitutional prohibition.

Any potential joint venture arrangement between hospitals and physician must be carefully and thoroughly scrutinized and structured to comply with the various applicable laws. However, mutually beneficial and legally compliant arrangements can be structured if the parties take the time to ask the right questions.

This article provides a general overview and commentary and is not intended to be legal advice regarding a particular hospital or physician's situation. The laws and regulations governing hospital and physician relationships are extremely complex and this article is not intended to be an in-depth analysis of the same. If you would like more information or have a specific question, please contact us.

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