Key Legal Issues Facing Physician Owned Hospitals

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I. Stark Act, Fraud and Abuse and False Claims Enforcement
   1. 700 cases regarding Fraud and False Claims
   2. 2,500 – 3,000 open FBI cases
   3. $2mm leads to $17mm
   4. Nearly $7 billion over 2.5 years

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II. Limit on increased Physician Ownership
III. Cannot require cases directly or indirectly
IV. No increase in beds, operating rooms or procedure rooms
V. Increased Disputes
   1. Redemptions
   2. Non competes

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VII. Bona Fide Investment
1. No financing of doctors share
2. Sale of share not based on value or volume
3. Sell at FMV
4. No guarantees to invest in ancillaries such as real estate

VIII. Transparency
1. Publish charges
2. Report physician owners & disclose prominently that hospital is physician owned
3. Advertising must disclose physician ownership
4. Physician owners must also disclose ownership at time of referral and the same must be a requirement for medical staff membership

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IX. Other Models
1. NFP
2. Management
3. Lease

X. Litigation Update

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XI. Pressure on Physician Relationships: 13 Key Considerations
1. Is the relationship truly needed? E.g., is a medical director necessary for the position? What value will this position add? Has the position been manufactured as an excuse to provide compensation to physicians?
2. Is the position and payment wholly unrelated to referrals or the intent to retain business? If any one purpose of a payment is in exchange for referrals, it can be deemed unlawful.
3. How comparable is the position to other positions in the hospital when it comes to specialties of lower financial value? I.e., is a position only funded because it relates to high value or volume specialties?
4. How comparable is the position to those at competing hospitals?
5. Is the payment fair market value? If so, what evidence supports this? Is there a third party valuation or objective, external evidence to defend this value?
6. Has the relationship between the hospital and the physician been approved by internal parties who are unrelated to the outside parties involved? I.e., is the physician who will receive such payment not part of the committee or board receiving such payment?

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7. Does the relationship meet a Stark Act exception and an Anti-kickback safe harbor? If a non-employment arrangement, is the relationship set to pay a fixed aggregate amount per year and not vary per the year? Many safe harbors require that aggregate payments be set in advance.
8. Can a rebuttable presumption under the Internal Revenue Code be obtained that the relationship doesn't create private inurement or excess benefit?
9. Has the hospital's compliance officer, or legal counsel, approved the relationship?
10. Is there a contracting file with legal and valuation approval? Has there been a comprehensive and detailed review of legal concerns?
11. Will the relationship be viewed in the context of an organization that has a culture of compliance?
12. Is there a short memo that supports the true need for the relationship?
13. Can this relationship be considered standard for the system, or is it highly creative and unusual?