Physician-Hospital Joint Ventures — Current Issues and Structures

By:
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This article discusses the proliferation of joint ventures between hospitals and physicians. Specifically, this article discusses the types of services that are being joint ventured, the types of structures being utilized, and certain of the key legal concerns relating to such issues and structures.

I. Types of Joint Ventures

Over the past few years, there has been a significant increase in the number of joint ventures between physicians and hospitals. This includes substantial growth with respect to ambulatory surgery center joint ventures and imaging facility joint ventures and includes to a lesser extent, growth with respect to joint venture dialysis facilities, cardiac catheterization facilities, and hospitals (principally specialty hospitals).

Joint venture ambulatory surgery centers ("ASCs") have experienced the most significant growth of all the possible joint venture structures. This is due, in part, to the fact that ASCs are not subject to the federal prohibitions on physician self-referral (the "Stark Act"). Moreover, ASCs are common enough that hospitals are concerned that if they do not joint venture such surgery centers, physicians will establish ASCs by themselves. In fact, in 2004, the number of ASCs established as physician-hospital joint venture surgery centers outpaced the number of surgery centers opened by solely physicians. There are currently approximately 4,400 to 4,600 ASCs in the country. Of these, nearly 1,200 have a hospital partner.

Imaging facilities, like ASCs, are also experiencing significant proliferation. Here, joint venturing imaging facilities is much more complex than joint venturing ASCs. This is in part because imaging facilities, except for positron emission tomography ("PET") centers, are subject to Stark Act prohibitions. This means that physicians and hospitals cannot joint venture the actual provider of imaging services, unless they are in rural areas or joint venturing with radiologists, or radiation oncologists with regard to radiation therapy. Thus, the parties must resort to other methods of trying to develop efforts aimed at jointly serving imaging needs. These can include, for example, time block, equipment leases and management models. These concepts are discussed more fully in Section II below.

There has been some development of joint venture whole hospitals between physicians and hospitals. This has largely been stalled by the moratorium set forth in the Medicare Modernization Act of 2003 with respect to specialty hospitals. The moratorium is set to expire on June 8, 2005, although it may be extended. Accordingly, there still remains some growth in this area and further development is expected if the moratorium is terminated.

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2 The Federal Ethics in Patient Referrals Act, 42 U.S.C. § 1395nn and 42 C.F.R. § 411.350 et seq. (the "Stark Act") prohibits, with certain exceptions, a physician who has a financial relationship (either ownership, compensation, or investment) with an entity from referring patients to that entity for the provision of "designated health services" if payment for those services may be made under Medicare or Medicaid. There are eleven designated health services to which the prohibition applies. However, 42 C.F.R. § 411.351 specifically excludes ASC services: "DHSS do not include services that are reimbursed by Medicare as part of a composite rate (for example, ambulatory surgical center services or SNF Part A payments) . . . ."

3 Positron emission tomography is a nuclear medicine procedure. Nuclear medicine procedures were exempted from the original Stark Act and that exemption was reaffirmed in the final regulations. To read the passages relevant to nuclear medicine see Federal Register, Vol. 69, No. 56, pp. 16107-04.

4 As part of the Medicare Modernization Act of 2003 ("MMA") Congress amended the Stark Act and ordered an eighteen month ban on physician billing of Medicare or Medicaid patients treated at any specialty hospital in which the doctor has a financial interest. Prior to this amendment, referring physicians were excepted from the Stark Act prohibition on referrals if they had an ownership interest in a "whole hospital."
Cardiac catheterization joint ventures were once thought to be the most likely growth area for joint ventures between physicians and hospitals due to the growth in cardiac catheterization and the desire of hospitals to develop stronger ties with their cardiologists. However, because certain of the services provided by cardiac catheterization facilities or laboratories can only be provided and billed as inpatient services, and due to licensing, reimbursement, and other issues, there has been significantly slower growth in the cardiac catheterization area than expected. However, as of 2005, there appears to be renewed growth in this area.

Finally, in the area of dialysis, where the joint venture typically occurs between a nephrology group and a hospital or national company, there has been substantial growth in the number of joint venture end stage renal disease (“ESRD”) dialysis facilities and the inclusion of hospital partners in such facilities. Here, ESRD facilities, like surgical centers, are not considered “designated health services.” Thus, there remains significant flexibility for joint venture models under a traditional joint venture structure.

II. Structure of Joint Ventures

There are several principal structures utilized for joint ventures. These models are subject to different legal risks and have various applicability depending upon whether a service is a “Stark” or non “Stark” service. The core models for joint ventures include: 1) a true or traditional joint venture, 2) an “under arrangements” joint venture, 3) a management services joint venture, 4) an equipment joint venture, 5) a gain sharing effort, and 6) a participating bond transaction. The core concepts related to each type of structure are as follows:

A. True Joint Venture

A traditional or true joint venture is a jointly owned entity. The entity has its own provider number, license and generally owns the assets that comprise the joint venture operations. The profits in the joint venture are split by ownership. This is the predominant model of joint venture for surgery centers, ESRD facilities and whole hospital or specialty hospital joint ventures. It is also often used for imaging facility joint ventures where a radiology group partners with the hospital or the venture is in a rural area. These joint ventures, as to surgical centers, are reimbursed based on the ASC payment group rates at the ASC freestanding rates set by Medicare. The division of ownership in these types of ventures depends greatly upon such issues as the market strength of the hospital, the presence or absence of a certificate of need requirement, and whether the venture is a start-up venture or an existing venture. The division of ownership also depends on the extent of capital available to the physician partners in the venture. Typically, these joint ventures are structured as limited liability companies (subject to certain tax concerns in certain states), and a board of managers is often elected in proportion to the ownership to manage the entity. The ventures may or may not have a management contract with the hospital or with a third party management company to oversee management.

B. Provider Based Joint Ventures

These joint ventures are often set up in a manner similar to the true joint venture. However, unlike a true joint venture, the joint venture entity often will not possess the license or provider numbers necessary for offering services. Rather, the sole principal customer of the joint venture will be the hospital. The hospital will furnish services “under arrangements” with the joint venture entity. The hospital will pay the joint venture for services and then bill for services as hospital outpatient department services. This structure allows the hospital to access higher reimbursement rates because outpatient services when billed by a hospital are reimbursed at a higher
rate than when an ASC bills for the same services provided in a surgery center. Higher reimbursement rates, together with the fact that these are shorter term arrangements, are the two perceived benefits of this model from a hospital perspective.

However, there is a significant divergence in viewpoints as to the permissibility of this type of structure under the Anti-Kickback Statute and Stark Act and from a billing perspective. From an anti-kickback perspective, the Office of Inspector General (“OIG”) issued a Special Advisory Bulletin in April 2003 on contractual joint ventures, contractual arrangements where a health care provider in one line of business (the “Owner”) expands into a related line of business by contracting with an existing provider (the “Manager”) of a related service to provide the service to the Owners’ existing patient population. The OIG is concerned by these contractual arrangements because unlike a true business enterprise, the Owner has contracted out substantially the entire operation of the new business to the Manager and the Owner’s primary involvement is its receipt of the profits related to patients it refers to the contractual joint venture. The OIG has continued to scrutinize arrangements which appear to have elements of a suspect contractual joint venture. While there was some initial concern as to whether the OIG would classify provider-based joint ventures as contractual joint ventures, the OIG clarified its position in January 2005, stating:

Standing alone, these “under arrangements” relationships do not fall within the scope of problematic contractual joint ventures described in the Special Fraud Alert; however, these relationships will violate the anti-kickback statute if remuneration is purposefully offered or paid to induce referrals (e.g., paying above market rates for the services to influence referrals or otherwise tying the arrangements to referrals in any manner). These “under arrangements” relationships should be structured, when possible, to fit within an anti-kickback safe harbor. They must fit within a Stark exception, even if the service furnished “under arrangements” is not itself a DHS.8

The OIG has further commented that hospitals should take steps to ensure that facilities or organizations are only designated as provider-based if they satisfy the criteria set forth in the regulations.9

For tax-exempt hospitals, this structure also raises questions from a tax exempt status perspective. This type of arrangement is often used for certain services where there is a clear and pressing requirement to use such structure. However, one should be skeptical in the use of this structure for a complete line of service.

C. Office Building and Ancillary Service Joint Ventures within such Buildings

These types of ventures have proliferated as the in-office ancillary service exception to the Stark Act requires that to be excepted from the prohibition on self-referrals, services must be furnished in either the same building where the physician or another member of the group furnishes substantial physician services unrelated to the Stark-covered services or in a centralized building used exclusively by the group to provide ancillary services.10 Here, the hospital or a third party may own imaging equipment in a medical office building. The physician practice may lease space in the medical office building. The physician practice may rent time in blocks from the hospital or third parties in order to provide services to their own patients. Under this model, the physician practice bills a third party for the services, pays the hospital or third party who owns the imaging equipment, and helps to arrange the services for use of the equipment. Here, the practice must meet a billing, location and supervision test and be able to defend themselves as the “provider” of the service. Further, certain services, where the physician is not actually the provider of the service are subject to certain

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6 Office of Inspector General, Special Advisory Bulletin: Contractual Joint Ventures, April 2003. The OIG noted that suspect arrangements contain one or more of the following: (i) a new line of business which is dependent upon referrals from the existing business; (ii) a captive referral base; (iii) little or no bona fide business risk; (iv) the status of the Manager as a would-be “competitor” but for the contractual arrangement; (v) the large scope of services provided by the Manager; (vi) the Owner’s receipt of residual profit from the new business which takes into account the volume and value of referrals; and (vii) the exclusivity of the arrangement.

7 Adv. Op. 04-17 (Dec. 10, 2004) (concluding that an arrangement whereby a company that arranged for the provision of pathology laboratory services would operate off-site pathology laboratories for physician group practices resembled a suspect contractual joint venture).


9 42 C.F.R. § 413.65 (2005) (setting forth the criteria for determining whether a facility qualifies as provider-based).

anti-markup and other rules related to purchased diagnostics.\textsuperscript{11}

D. Equipment Joint Ventures

In these types of joint ventures, the hospital and physicians will jointly own equipment through an entity. This equipment can be rented to either the hospital or the physician practice which will then operate the equipment, on either a flat annual fee basis or a per click basis. Per click fair market value leases have been found not to violate the Stark Act. Such leases may still raise issues under the anti-kickback statute in that they do not fit within a safe harbor. Often, over time, parties find that these types of equipment lease joint ventures do not satisfy the business objectives of the parties. In short, if the interests are fully congruent between a hospital and the physicians (i.e., the physicians profit more surgery) the more likely the arrangement will be found to be violative of the Anti-Kickback Statute. These arrangements are often easier to defend where the equipment at issue is very expensive and there are legitimate capital reasons why the hospital may not desire to buy such equipment (i.e., a lithotripter or gamma knife).

E. Management Services Joint Venture

In this type of joint venture, either the physician practice or the hospital manages a service for the other party. Alternatively, the practice and hospital may operate a management company to manage a line of business of a surgery center or some other entity. For example, a hospital may manage a Stark service of a practice in lieu of a true joint venture. Alternatively, the practice or group may provide management services to a hospital’s business line or segment of operation. Here, it is often challenging to develop fee structures that are lawful but that also meet the goals of the parties. Further, one needs to justify why one would be using a physician driven management company to manage a service when there are other parties that may have national reputations in providing such services with national experience. In addition, with respect to any type of fee, the parties will need to be able to support that the fee is at fair market value and not related to the volume or value of referrals. Thus, even a management fee that is based upon a fee model used by a national company may raise additional issues and challenges when used by the group that makes referrals to the hospital.

F. Gain Sharing

The Office of Inspector General of the Department of Health and Human Services (“OIG”) has recently approved certain gain sharing arrangements.\textsuperscript{12} In these types of arrangements, a hospital will pay a certain group, for example a group of surgeons, a share of any first year savings directly related to specific changes in the surgical group’s operating room practices. Typically, these arrangements are relatively short term. It is important to structure these arrangements in a way that ties results and payments to cost reductions but avoids ties to volume. Specifically, the OIG commented:

- Properly structured, arrangements that share costs savings can serve legitimate business and medical purposes. Specifically, properly structured arrangements may increase efficiency and reduce waste, thereby potentially increasing a hospital’s profitability. However, such arrangements can potentially influence physician judgment to the detriment of patient care. Our concerns include, but are not limited to, the following: (i) stinting on patient care; (ii) “cherry picking” healthy patients and steering sicker (and more costly) patients to hospitals that do not offer such arrangements; (iii) payments in exchange for patient referrals; and (iv) unfair competition (a “race to the bottom”) among hospitals offering cost savings programs to foster physician loyalty and to attract more referrals.\textsuperscript{13}

Under many of these types of arrangements, the cost savings structures may be of limited longer term

\textsuperscript{11} The Medicare Purchased Diagnostic Test Rule (“PDTR”) (Medicare Carrier Manual § 15048) provides that if a physician bills for diagnostic tests performed by an outside supplier, the physician cannot be paid by Medicare for more than what the supplier charged. To avoid the anti-markup provisions of the PDTR, the physician must, at a minimum, personally perform the tests or supervise it, or have it supervised by another physician in the practice.


\textsuperscript{13} Adv. Op. 05-06 (Feb. 25, 2005).
use in that payment is tied to showing cost savings for a relatively short period of time.

G. Participating Bond Transactions

Over the last few years, there has been increased discussion of a business model that uses participating bonds. Participating bond transactions involve a situation where a hospital develops a facility and typically, as part of the financing, a small part of the entire financing is raised through issuance of "participating bond transaction" bonds. The participating bonds are generally intended to be tax exempt and often pay a much higher rate of interest than typical financing. Often, these bonds must be offered not just to physicians but to a slightly larger and broader group of participants. The benefits of the use of participating bonds is that they provide physicians a return on investment but allow the hospital to maintain principally all control. The principal downside is while the bonds may provide a guaranteed return it is not the same kind of return that is consistent with actual ownership of a provider. Further, the bonds may not provide physicians with the type of control they otherwise might prefer to have.

III. Key Legal Issues

There are approximately, ten to twelve key legal issues involved in structuring joint ventures between physicians and hospitals. These include the following: (a) issues raised under the Stark Act; (b) issues raised under the Anti-kickback Statute; (c) issues raised under state self referral acts; (d) where tax exempt hospitals are involved, issues raised with respect to the hospital's 501(c)(3) status and the operation and organization of the joint venture; (e) issues raised under certificate of need laws; (f) issues raised under federal and state antitrust laws; (g) issues relating to the billing of services either with respect to use of an "under arrangements" model or with respect to purchased diagnostics in an MRI or imaging facility; (h) issues with respect to the affiliated service group rules and the impact on pension plans where physicians and hospitals jointly own and operate facilities; and (i) issues raised under the securities laws with respect to the sale and issuance of ownership in facilities.

These are the principal types of legal issues that relate to these types of joint ventures. There are also several other business and structural issues.

A brief summary of these is as follows:

A. The Stark Act.

The Stark Act specifically restricts the ownership and operation of certain types of providers by physicians. With respect to joint ventures, it is a critical statute because it essentially outlaws joint ventures where a service is a Stark service. With respect to the types of joint ventures stated above, typically, ambulatory surgery centers and dialysis facilities are not Stark services. Thus, they can be established as a true joint venture. In contrast, imaging services, except for PET services and nuclear services, are considered Stark services. This means there are substantially greater restrictions on the ability to joint venture imaging services. Traditionally, there has been an exception for ownership by physicians of whole hospitals generally. Cardiac catheterization, for the most part, is not considered a Stark service. Thus, again, cardiac catheterization services can be joint ventured under the Stark Act. However, there are other restrictions on such ventures.

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14 Pemberton, Gregory L. and Jamie R. Brashear, Tax-Exempt Fundamentals, PRACTICAL TAX LAWYER, Winter 2004 (providing a brief overview of participating bond transactions); Sullivan, T.I., Representing and Managing Tax-Exempt Organizations, GEORGETOWN UNIV. LAW CTR. CONTINUING LEGAL ED., April 2004 (noting that these transactions have not been thoroughly evaluated by the IRS or other regulators but raise unique tax and regulatory issues that must be addressed).

15 As noted earlier, the eleven designated health services (i.e., Stark services) include: clinical laboratory services, physical therapy services, including speech-language pathology services; occupational therapy services; radiology and certain other imaging services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.

16 Nuclear medicine has been excluded from the list of designated health services. However, CMS has commented that although PET scans and nuclear medicine procedures are not Stark services, arrangements involving nuclear medicine may violate the Anti-Kickback Statute depending on the circumstances. To read the paragraphs relevant to nuclear medicine see Federal Register, Vol. 69, No. 56, pp. 16102-04.

17 See 42 U.S.C. § 1395w(d)(3). See also footnote 3 summarizing the recent Congressional activity relating to the whole hospital exception. More recently, MedPac and the Department of Health and Human Services have compiled studies related to physician ownership of hospitals.
B. The Anti-kickback Statute.

Joint ventures raise many issues under the Anti-Kickback statute. The OIG promulgated safe harbor regulations for certain arrangements which do not pose a risk of fraud and abuse.\(^{18}\) Included among the safe harbors is a safe harbor for ambulatory surgery center joint ventures.\(^{19}\) There are safe harbors, for example, for lease and management arrangements and for investments in smaller investment entities.\(^{20}\) There is not a specific safe harbor for other types of health care providers besides ASCs.

With respect to joint ventures which will not meet a safe harbor, one must make the argument that a return on ownership itself is not remuneration or that compensation is not in exchange for referrals. Then, one must implement a number of steps to help clarify that the parties are not receiving any sort of a special compensation or remuneration as a result of being owners in the joint venture. For example, a party is not required to make referrals, a party is not able to buy shares below fair market value, or a party is not receiving a special medical director or compensation relationship. In lease transactions, one must be able to defend the concept that the equipment lease is fair market value and that one is not paying any sort of greater price based on the fact that the physician owners of the equipment can make referrals to the venture. A similar analysis must be made with respect to management services. In essence, one needs to show that the physician or physician-owned entity is being chosen as a manager based on his or its skill and ability to manage the facility and that the payments will be at fair market value amounts and not any higher or lower than the payments would be if the parties were not physicians. In the case of the “under arrangements” joint ventures, where the payment may be a per click payment, one must be able to defend the fact that if the hospital were to develop the service itself, it would be paying for staff and equipment at essentially a cost amount, rather than simply paying an amount that is typical to pay for such procedures as it does in an “under arrangements” venture. In essence, rather than paying a flat fixed amount for labor, equipment or the cost, the hospital is paying a per procedure cost which may be higher in the aggregate.

C. State Self Referral Laws.

Many state self referral laws mirror those of the Stark Act. With respect to completing a joint venture in a specific state, it is critical that a party examine fully the state self referral laws of that state and its impact on the potential joint venture.\(^{21}\)

D. Tax Exempt Entity Involvement.

There are two core issues with respect to the inclusion of a tax exempt partner in a joint venture. First, the exempt party typically desires to treat the income of the joint venture as exempt from taxation (i.e., not subject to tax as “unrelated business income”). Second, the tax exempt entity desires to ensure that its involvement in the joint venture, even if the income is taxed, will not have a negative impact on the tax exempt status as a whole. To this end, the joint venture in which the tax-entity invests must be organized and operated in a manner that allows the joint venture to serve the community and charitable purposes of the tax-exempt partner.\(^{22}\) Internal Revenue Service guidance provides:

The determination as to whether a joint venture furthers the charitable purposes of the exempt nonprofit partner, and whether the arrangement permits the exempt partner to act exclusively in furtherance of its exempt purposes and only incidentally for the benefit of the for-profit partner, is based on all of the facts and circumstances. The revenue ruling [Rev. Rule 98-15] considers whether or not the exempt partner has been able to maintain sufficient control over its activities for it to be able to establish that it will be operated exclusively for exempt purposes. It is not a narrow look at control.\(^{23}\)

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\(^{18}\) 42 C.F.R. § 1001.952(a)-(u). Under the regulations, arrangements which satisfy all of the requirements of the safe harbor are immune from both criminal prosecution and administrative enforcement by the OIG.

\(^{19}\) 42 C.F.R. § 1001.952(c).

\(^{20}\) 42 C.F.R. § 1001.952(c), (d), and (a).


\(^{22}\) I.R.C. § 501(c)(3). To qualify as a tax-exempt organization, an entity must (1) organized and (2) operated exclusively for one or more charitable purposes. Moreover, a 501(c)(3) entity must furnish a public benefit through its activities and there cannot be more an incidental private benefit and inurement.

The core challenge with respect to tax exempt issues is balancing the needs of the hospital to have comfort that the joint venture will not negatively impact the status of its income with the need of physicians to have significant control over the joint venture in which they are investing.

E. Certificate of Need.

In many states, to develop a new health service, a party is required to obtain a Certificate of Need ("CON"). In approximately 25 states there is not a CON requirement applicable to surgery centers. In contrast, in 25 other states there remains a CON requirement for surgery centers. In CON states, the parties must determine whether there is an exemption for the CON law or whether they can obtain a CON. In many states, it is immensely easier to obtain a CON if there is a hospital partner in the joint venture. Thus, the hospital often has greater bargaining power in developing the joint venture structure than in other states.

F. Billing and Anti-Markup Issues.

Billing issues are raised in two different contexts. First, in an "under arrangements" model, it is possible that a joint venture may be challenged for billing as a hospital outpatient department as opposed to a freestanding joint venture. Second, where physicians purchase imaging blocks or other types of operations from others, they run the risk that they are not viewed as the provider of services. Moreover, if they are billing for such services at a markup, this raises issues under the Anti-Kickback Statute and the purchased diagnostics rule, specifically, where a physician purchases diagnostic services, and then resells such amounts.

G. Affiliated Service Group Issues.

Generally, parties desire to avoid a situation where their own practice is deemed affiliated for pension purposes or those of the joint venture. There are a number of rules that impact on this type of analysis.

H. Securities Law Issues.

In developing a joint venture, depending upon the number of potential participants and whether the parties are forming a joint venture together or whether one party is selling interests to another, an issue may be raised as to whether one is selling securities to others. Where a party is selling securities, it is important to assure that one meets an exemption for the sale of securities under each state and federal law perspective. From a federal law perspective, this typically means trying to assure that the transaction will fit into a Regulation D securities law exemption. From a Regulation D exemption, there is a specific breakdown as to the type of information that must be provided to a potential buyer based on the status of the buyer. For example, if a person will be a manager in the venture, a director, an officer, or the person will meet certain economic requirements such as net worth income requirement, it is likely that the person will not be required to receive information pursuant to the requirements of Regulation D. In contrast, where a person does not meet these types of tests, there are specific requirements for information and disclosure to the person. These types of disclosures can certainly raise the cost of putting a venture together by a significant degree. A further benefit of putting this type of information together, regardless of whether the person is accredited or nonaccredited, is that they may provide protection under other types of federal or state securities laws.

ventures with for-profit entities. The Internal Revenue Service ("IRS") analyzed two fact patterns, one of which was permissible and one of which resulted in revocation of tax-exempt status. The general concepts coming out of the permissible fact pattern involved tax-exempt partner having significant board and operational control. In addition, the governing documents required the venture to serve community needs.