Hospital-Physician Integration Models: *An Alternative to Joint Ventures*

By:

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Many hospital systems, over the last several years, have tended to avoid the large scale employment of physicians or the acquisition of practices. This history resulted from many of the financial problems hospitals encountered from acquisitions and expansion in the 1990s. During that period, many systems literally bankrupted themselves due to practice acquisition and employment costs. Hospitals, for many reasons, including the need to assure coverage and the need to provide a wide range of services, are again acquiring practices and employing physicians.

A good deal of the more recent activity focuses on surgical and other specialists, as opposed to primary care physicians. It has resulted in part from a recognition that joint ventures and other partial integration models are terrific tools for certain situations. However, joint ventures do not meet certain needs. Here, fuller integration models are again being used as alliance models.

This article briefly discusses three full integration models. It provides a preliminary overview of certain tax exemption issues, Stark Act issues, anti-kickback statute ("Fraud and Abuse Statute") issues and corporate practice issues. This is not intended to be a comprehensive article. It also does not discuss in any detail several issues ancillary to such transactions and relationships, nor does it discuss several issues relevant to the initial "acquisition" or other transaction that is often a prerequisite step to such relationships.[2]

The three key models discussed in this article are as follows:

I. Direct employment;

II. Subsidiary of hospital, whether a limited liability company or corporate entity "not-for-profit" or "for-profit"; and

III. Affiliated practice structure (whether foundation, not for profit or for profit model).

There are also variations on each type of model.

I. Direct Employment Model. The direct employment model has the principal advantage of having the most flexibility from a Fraud and Abuse Statute and Stark Act perspective. Briefly stated, under an employment model, payments to a physician will generally meet a safe harbor under the "bona fide employee safe harbor" to the Fraud and Abuse Statute. The prohibitions contained in the Fraud and Abuse Statute do not apply to ". . . any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services. . . ."[3] The Regulations promulgated by the Center for Medicare and Medicaid Services provide additional guidance as to the meaning of the exception.

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[2] The initial transaction, for example, must be structured to meet an "isolated transaction" rule under the Stark Act, and must not provide for improper benefit or private inurement. Then, the ongoing compensation for services must meet Stark Act, Fraud and Abuse and tax exempt requirements as to payment amount and methods. The Stark Act permits a one-time, isolated transaction provided the amount paid in the transaction represents the fair market value and such amount is unrelated to the volume or value of referrals. The Stark Phase II regulations allow customary post-closing adjustments if they are not dependent on referrals and are made within six months of the date of the transaction. Installment payments are permitted if they are fully set before the first payment is made, do not take into account the value or volume of business generated by the referring physician, and the outstanding balance is guaranteed by a third party, secured by a negotiable promissory note or subject to a similar mechanism. For a more complete discussion of physician practice and integration transactions and physician compensation issues, *see* Health Care Law: A Practice Guide, Scott Becker, Chapter 3, Chapter 4 and Chapter 11.

[3] 42 USC § 1320a–7b(b)(3)(B).

A. Fraud and Abuse Statute Safe Harbor and Stark Act Exception

1. Fraud and Abuse Safe Harbor

Employees. As used in section 1128B of the Act, "remuneration" does not include any amount paid by an employer to an employee, who has a bona fide employment relationship with the employer, for employment in the furnishing of any item or service for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs. For purposes of paragraph (i) of this section, the term employee has the same meaning as it does for purposes of 26 U.S.C. 3121(d)(2).[4]

2. Stark Act Exception

The direct employment model also can rely upon a specific exception to the Stark Act:

> Exceptions relating to other compensation arrangements. The following shall not be considered to be a compensation arrangement described in subsection (a)(2)(B):
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> . . .
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> (2) *Bona fide employment relationships.* Any amount paid by an employer to a physician (or an immediate family member of such physician) who has a bona fide employment relationship with the employer for the provision of services if—
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> (A) the employment is for identifiable services,
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> (B) the amount of the remuneration under the employment—
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> (i) is consistent with the fair market value of the services, and
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> (ii) is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician,
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> (C) the remuneration is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the employer, and
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> (D) the employment meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.
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> Subparagraph (B)(ii) shall not prohibit the payment of remuneration in the form of a productivity bonus based on services performed personally by the physician (or an immediate family member of such physician).[5]

B. Fair Market Value is Critical

The principal restriction is assuring that the physician compensation is fair market value and meets the tests set forth for developing the "rebuttable presumption" as to fair market value. The Stark Act provides a specific method to obtain a "safe harbor" as to the fair market value nature of the compensation. From a tax exempt perspective, there is also a method by which an exempt entity can obtain a presumption that compensation is appropriate. Briefly stated, the compensation (1) must be approved by the governing body composed entirely of persons without a conflict of interest, (2) the body must rely on appropriate data obtained prior to making its determination, and (3) the body must document the basis for its determination. These rules regarding the appropriateness of compensation, and the methods by which to define the compensation amounts, will generally apply to each of the three integration options discussed herein.

Fair market value has generally been defined by the Department of Health and Human Services ("DHHS") as follows:

> Fair market value means the value in arm's-length transactions, consistent with the general market value. "General market value" means the price that an asset would bring as the result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the service agreement. Usually, the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition, or the compensation that has been included in bona fide service agreements with comparable terms at the time of the agreement, where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals.

[4] 42 CFR 1001.952(i).

[5] 42 USC 1395nn(e).

Stark Fair Market Value Exception

The Stark Exception as to the fair market value nature of compensation is set forth as follows:

An hourly payment for a physician's personal services (that is, services performed by the physician personally and not by employees, contractors, or others) shall be considered to be fair market value if the hourly payment is established using either of the following two methodologies:

(1) The hourly rate is less than or equal to the average hourly rate for emergency room physician services in the relevant physician market, provided there are at least three hospitals providing emergency room services in the market.

(2) The hourly rate is determined by averaging the 50th percentile national compensation level for physicians with the same physician specialty (or, if the specialty is not identified in the survey, for general practice) in at least four of the following surveys and dividing by 2,000 hours. The surveys are:

- Sullivan, Cotter & Associates, Inc.—Physician Compensation and Productivity Survey
- Hay Group—Physicians Compensation Survey
- Hospital and Healthcare Compensation Services—Physician Salary Survey Report
- Medical Group Management Association—Physician Compensation and Productivity Survey
- ECS Watson Wyatt—Hospital and Health Care Management Compensation Report
- William M. Mercer—Integrated Health Networks Compensation Survey[6]

C. Disadvantages of Direct Employment Model

The principal downside to a direct employment model is twofold. First, the employing entity (i.e., the medical center) has liability for the malpractice of the physicians. Second, it can be difficult, from a governance and ego perspective, to "sell" to the physicians the concept that they will be direct employees of a hospital. While there can be provisions in the employment agreement regarding governance of the employed physicians individually and as a group, the procedure is different than in a separate entity where there may be a physician governing board or other types of governance provisions that would give the physicians greater control and authority.

[6] 42 CFR § 411.351.

D. Directing Referrals

Under an employment model, the principal restriction on payment is tied to assuring that payments are not more than fair market value. However, there still remains the concept of not being able to pay a physician based on the profits of the institution or for the services that they generate or refer. Fortunately, the Stark Act contains language that provides a system with a substantial amount of flexibility to require and encourage use of the hospital and its affiliates by the employee.

A physician's compensation from a bona fide employer or under a managed care or other contract may be conditioned on the physician's referrals to a particular provider, practitioner, or supplier, so long as the compensation arrangement:

(i) Is set in advance for the term of the agreement;

(ii) Is consistent with fair market value for services performed (that is, the payment does not take into account the volume or value of anticipated or required referrals);

(iii) Otherwise complies with an applicable exception under § 411.355 or § 411.357;

(iv) Complies with the following conditions:

(A) The requirement to make referrals to a particular provider, practitioner, or supplier is set forth in a written agreement signed by the parties;

(B) The requirement to make referrals to a particular provider, practitioner, or supplier does not apply if the patient expresses a preference for a different provider, practitioner, or supplier; the patient's insurer determines the provider, practitioner, or supplier; or the referral is not in the patient's best medical interests in the physician's judgment; and

(v) The required referrals relate solely to the physician's services covered by the scope of the employment or the contract and the referral requirement is reasonably necessary to effectuate the legitimate business purposes of the compensation relationship. In no event may the physician be required to make referrals that relate to services that are not provided by the physician under the scope of his or her employment or contract.[7]

[7] 42 CFR § 411.354(d)(4).

E. Corporate Practice of Medicine

There are, of course, other legal considerations to consider beyond the Fraud and Abuse and Stark Act implications of the employment model. For instance, in some states, the corporate practice of medicine doctrine may prevent the direct employment of physicians by certain entities. There is often an exception to such laws that allows hospitals to employ physicians.

Commentators have noted the following regarding the corporate practice of medicine doctrine: "[o]ne of the principle mechanisms by which states restrain lay ownership of medical practices is a collection of rules and statutes generally known as the "corporate practice doctrine. This doctrine includes prohibitions against corporate employment of physicians and against the unlicensed corporate practice of medicine."[8] However, "[t]he doctrine is riddled with exceptions; many states ignore the doctrine and some out rightly have refused to enforce the doctrine. Changes in the healthcare industry have also contributed to the demise of the corporate practice prohibition. . . ."[9] "In some jurisdictions, courts have gone out of their way to infer exceptions for specific practices. . . ."[10]

II. Subsidiary of Hospital. A hospital will often employ physicians through a subsidiary, whether a corporation or an LLC. Here, the corporation owned by the hospital would employ the physicians and enter into an employment agreement with them. The subsidiary, subject to tax exempt control issues, may have governance provisions and different types of committees where the physicians have a wide degree of latitude. However, the hospital must retain enough control to help assure that it is deemed to be consistent with the hospital's tax exempt purposes and serving community purposes. Thus, the hospital often has certain unilateral and reserve powers to assure that the subsidiary and its physicians are serving community purposes.

[8] Andrew Fichter, *Owning a Piece of the Doc: State Law Restraints on Lay Ownership of Healthcare Enterprises*, 2006 AHLA, Journal of Health Law, Vol. 39, No. 1, HOSPLW Pg. 14.

[9] *Id.* at P. 50, quoting Judith Parker, *Corporate Practice of Medicine: Last Stand or Final Downfall?* 29 J. HEALTH & HOSP.L. 168 (1996).

[10] *Id.* citing Mark A. Hall & Justin G. Vaughn, *The Corporate Practice of Medicine in Healthcare Corporate Law: Formation and Regulation*, § 3.4, at 3-13 to -14 (Mark A. Hall ed. 1999).

A. Serve Charitable Purposes

The hospital will need to assure that the subsidiary, for example, (1) serves charity, Medicaid and Medicare patients; (2) has a charity care policy; (3) broadcasts such policy; and (4) catalogs the charitable services and benefits provided by the subsidiary practice.

B. Directing Business

Under this type of subsidiary model, even though many institutions do require that the physicians utilize the hospital for services, there is not actually great clarity from a Fraud and Abuse Statute and Stark Act perspective as to the ability to direct physicians to utilize the hospital. Further, there is potentially greater scrutiny as to the payment amounts made by the hospital to the subsidiary to provide funding to the subsidiary. That stated, as long as it can be demonstrated that the physicians are not paid more than fair market value, there is generally good latitude to help justify and support the amounts that do flow from the hospital to the subsidiary. For example, in some situations, the subsidiary is owned by the hospital and often or always loses money. Here, it is critical that the actual amounts paid to the physicians in the practice are defensible as fair market value payments.

C. Stark Group Practice

The "practice," even if owned through a subsidiary of the hospital, may be established as a "group practice" which can allow the practice physicians to profit from ancillary services[11] provided within the practice. To qualify as a group practice, the hospital can own the practice and the practice must have at least two (2) employed physicians. The group practice must then meet all of tests for a group practice under the Stark Act to provide designated health services and the services must be provided directly by the designated group practice for the income to be shared within the group. The hospital can have several different distinct group practices.

[11] *See* 42 CFR § 411.355(b), which sets forth the direct supervision, building, and billing requirements which must be met under the Stark Act's in-office ancillary services exception.

III. Affiliate or Foundation Model. There are many different ways to structure an affiliate or foundation model. In a true foundation model, the great majority of the board is controlled by an exempt entity or community appointees who are persons independent of physicians. The foundation charter and governing documents also typically include a great deal of language that will assure that the foundation serves charitable and community purposes. In addition, there is a prohibition against excessive private inurement of benefits to parties that are not part of the charitable class.[12]

A. Independent Foundation Board

The foundation, if operated appropriately, is able to accept tax free grants and other types of donations. Traditionally, 80% of the board of the foundation has to be independent of the physicians.[13] The income earned by the foundation is also exempt. The foundation can also receive gifts that are deductible by the parties making the gifts. In a foundation model, the hospital may also have a contract to manage the practice. This may be a traditional "all services" model or may be an a la carte or management services bureau model.

B. Corporate Practice of Medicine

In certain states, particularly "corporate practice states," an affiliated captive practice model, as opposed to a foundation model, is set up to operate the practice. In this model, the stock of the corporation is held by a physician, often a chief medical officer or vice president of physician affairs at the hospital. He or she has nominal value in the corporation and the hospital retains control over the transferability of the shares and the share ownership is tied to continued employment with the hospital. Then, the hospital has the right to have the physician entity shares transferred to another party when that physician is no longer affiliated with the hospital.[14]

C. Different Levels of Autonomy

We have also seen other affiliated physician models evolve where the physicians are more independent of the hospital although they have been developed in alliance with the hospital. This type of multi-specialty clinic may have multiple different relationships with the hospital. For example, it may have contracts to provide emergency services, anesthesia services and other hospital-related services. It may also have stipends or directorships for other types of services. Further, it may have "exclusive relationships" within certain specialties. The hospital may or may not have board seats on the practice or other influence on the practice. The affiliated practice provides a central means by which the hospital can work with a practice to help meet hospital needs on an ongoing basis. For example, as recruiting is needed in the area, the hospital may first talk with the practice about helping to meet those needs. This model can work where a hospital and physicians have some truly congruent interests. For example, they may own interests in certain ancillary businesses together, they may own interest in infrastructure assets together, they might even own interest jointly in a hospital, or they may have other common goals. It can be more difficult to make this model work when the practice and hospital do not

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[12] Internal Revenue Manual, 7.25.3.16 - Inurement, Private Benefit, and Intermediate Sanctions (02-23-1999):

(1) An otherwise qualifying organization will be disqualified for exemption if it excessively benefits private interests, either through inurement of its net earnings to certain "insiders" or by primarily benefiting the interests of persons who, though not "insiders," do not comprise a charitable class.

(2) Inurement and private benefit are often incorrectly used interchangeably. This can cause confusion and lead to incorrect analysis. The critical distinction is that "private benefit" is broader than "inurement." Thus, all inurement is private benefit, but not all private benefit is inurement.

(3) The distinction was given added significance by the addition of IRC 4958. The excise tax on "excess benefit transactions" imposed by that section was intended to provide an intermediate sanction short of revocation to transactions constituting inurement.

(4) Technical advice must be requested in any case in which the excise tax on intermediate sanctions is proposed or revocation of exemption because of inurement is an issue, including any case in which those issues are resolved through a closing agreement.

[13] *See* Internal Revenue Service Exemption Ruling dated April 4, 1994 and PLR 9817035, 1998 WL 196883 (IRS PLR).

[14] *See* Fichter, supra note 8, at Pg. 56 (noting that one method of circumventing state laws that prohibited physician employment by "lay-owned corporations" was to "employ . . . a 'captive PC' or professional corporation whose stock is owned entirely by one or more professionals contractually bound to the lay-owned entity in a manner assuring control by the lay-owned entity").

have these kinds of stronger and more congruent alliances. For example, where the physicians are really independent of the hospital and ultimately may have leadership that is interested in strongly developing its own ancillary capacities and efforts, this model may not work. Further, this type of affiliated method model may cause much more difficulty in attempting to jointly contract for services with third party payors.

IV. Other Legal Considerations. There are other considerations that should be discussed in developing an integration model. These will include additional issues related to (1) compliance with the Fraud and Abuse Statute and Stark Act, (2) understanding which model provides for easier joint or integrated managed care contracting (i.e., which model raises the least amount of antitrust concerns) and the antitrust laws and their application to the acquisition or practice integration efforts, (3) assuring any acquisition of assets can be defined as being at fair market value, (4) understanding which entities can qualify for tax exempt treatment and which are not likely to qualify for such treatment, (5) employee benefit and retirement plan issues, (6) additional corporate practice of medicine issues, (7) fee splitting issues, and (8) several other related legal and business issues.