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# HOSPITAL-PHYSICIAN JOINT VENTURE RELATIONSHIPS: A USEFUL TOOL TO IMPROVE HOSPITAL SERVICES

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## I. INTRODUCTION

Hospitals faced with mounting pressure to stay financially viable must contend with an increasingly complex environment where competition, pressure to reduce costs, and constant government scrutiny must be carefully factored into every business growth decision. For those hospitals that are tax-exempt, maintaining their exempt status is complicated by additional factors such as political pressure to provide more charity care,[1] response to public concerns when medical mistakes or poorly provided care occurs within their institutions,[2] and the criticisms of high compensation paid to hospital executives.[3] When hospitals also factor in the need to stay competitive while controlling costs, it is not surprising that many search for innovative ways to improve efficiency and minimize spending in order to remain current with their competitors. One market strategy that has gained favor in allowing hospitals to expand health care services and business opportunities in their communities has been the use of an "under arrangements" relationship,[4] or an arrangement pursuant to a "provider based" arrangement.[5] While "under arrangements" have been recognized for many years by the federal government as a legitimate model for providing health care services, these "partnerships" have been gradually gaining renewed popularity as hospitals have sought to increase physician involvement in efforts to expand market share and increase the quality of patient care. Hospitals have progressively realized that the joint venture business model provides a unique

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[1] *See* Fred Bazzoli, *Grassley Continuing to Increase Pressure for Community Benefit Reporting*, HEALTHCARE FIN. NEWS, Jan. 1, 2007, at http://www.healthcarefinancenews.com/story.cms?id=5764.

[2] *See* Vic Ryckaert, *Baby's Kin Blame Nurses for Her Death*, INDIANAPOLIS STAR, Sept. 22, 2006, at A1.

[3] *See* Walt Bogdanich, *Hospital Chiefs Get Paid for Advice on Selling*, N.Y. TIMES, July 17, 2006, at A1.

[4] 42 U.S.C. § 1395x(w) (2000).

[5] *See* 42 C.F.R. § 413.65 (2006).

opportunity to partner with specialty doctors to provide sophisticated services that are relevant to what the market demands while allowing the hospital to branch out into new markets.[6]

## II. THE BENEFITS OF PARTNERING WITH PHYSICIANS IN JOINT VENTURES

Traditionally, the use of services providing "under arrangements" has allowed a hospital to obtain specialized health care services that it was otherwise unable to provide or secure services that could be provided more effectively by a subcontractor, such as a laboratory or occupational therapy service provider. The current movement to "under arrangement," "provider based," and other business or joint ventures between hospitals and physicians has allowed hospitals to remain competitive in an environment where inpatient hospital days are dwindling due to the continued flow of health services and procedures to the outpatient setting.[7] In practice, these arrangements are increasingly being utilized in the form of joint ventures between hospitals and specialty physician groups.[8] The use of joint ventures is appealing to hospitals because it allows them to engage a third party (often a physician group) to perform certain services on behalf of the hospital while allowing the hospital to lawfully bill Medicare and other third-party payors for the services provided. Further, it allows hospitals an opportunity to increase access for their patients to clinical experts in highly specialized areas such as cardiology. While working in collaboration with physicians has been a significant challenge for some hospital systems, the traditional walls between physicians and hospitals are being torn down as the demand for high quality care, more efficient care, and greater access to higher-end technological treatments requires an innovative approach to structuring business arrangements.

In order to maintain a viable joint venture relationship, the hospital must assume the responsibility to ensure the arrangement complies with certain government regulations in order to receive reimbursement from the federal government for services provided through the partnership. Hospitals have ultimate accountability to ensure that all health care services provided as hospital services are properly designed, organized, and evaluated as part of their ongoing utilization review, quality assurance, and peer review activities.[9]

In this era of cost-effective health care, where there are parallel demands by patients for higher quality care and by physicians for increased control and financial security in the marketplace, the use of a joint venture relationship al-

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[6] HEALTHCARE FIN. MGMT. ASS'N, FINANCING THE FUTURE II REPORT 4: JOINT VENTURES WITH PHYSICIANS AND OTHER PARTNERS 4 (2006) [hereinafter FINANCING THE FUTURE REPORT 4].

[7] FITCH RATINGS.COM, Outpatient Business Growth: Nonprofits Hospitals' Struggle for Volume (Sept. 10, 2004), http://www.fitchratings.com/corporate/sectors/report_index.cfm.

[8] Ira J. Rappeport, *"Under Arrangements" Joint Ventures: A Newly Popular Form of Hospital-Physician Integration*, BOARDROOM PRESS, THE GOVERNANCE INSTITUTE, Aug. 2005.

[9] 42 U.S.C. § 1395x(w) (2000).

lows hospitals and physicians to align common incentives and financial goals to work together to improve the quality and efficiency of care, and meet the growing needs of the health care market.

### *A. Joint Ventures' Emergence as a Preferred Under Arrangement*

The continuing pressure to modernize services and act in accordance with ever-changing federal and state regulatory requirements often creates additional obstacles for hospitals seeking to improve care and further develop their service lines.[10] Government and private payors, however, are beginning to look for ways that health care providers can work together to improve the quality of care and create positive health outcomes for their beneficiaries. Recently, the government demonstrated this commitment to finding new solutions to promote quality care by becoming more flexible and supportive of collaborative efforts in the marketplace between hospitals and third parties.[11] For example, the government approved select gain-sharing arrangements and ultimately revoked the moratorium on specialty hospitals' construction.[12] With limited but growing government acceptance, hospitals are reconsidering how to creatively collaborate with physicians to decrease costs and improve overall health care utilization. The trend for many hospitals has been to capitalize on the movement towards investing in specialty hospital services by seeking to partner with physicians who are positioned to expand specialized services, or to capture new and growing markets along a specific service line, such as diagnostic imaging. The use of a joint venture with physicians, whether structured pursuant to the "under arrangements" rules, the "provider based" rules, or another model, provides hospitals and physicians with a powerful tool to collaborate on managing long-term costs while concurrently improving quality and clinical outcomes.[13]

Joint ventures can involve either a short or long-term relationship. Usually the partnership developed is between a hospital or health system and a provider entity (usually a physician group) where the risk and benefits are shared with the purpose of creating a common business enterprise to expand or provide new services.[14] Joint ventures can be generally characterized in one of three ways: defensive, offensive, or a combination of the two.[15] Defensive joint ventures are typically formed where the hospital has a perceived or real threat from

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[10] John R. Boettinger, Jr. & Teresa T. Young, *Healthcare Joint Ventures: A CFO Primer*, HEALTHCARE FIN. MGMT., Oct. 2004, at 36, 36-40.

[11] James J. Pizzo & Lewis Redd, *Hospital-Physician Joint Ventures: Maximizing the Potential*, HEALTHCARE FIN. MGMT., Nov. 2006, at 80, 80-83.

[12] Jessica B. Applegate & Kathy Kuhagen, *Deficit Reduction Act of 2005 Addresses Various Health Issues*, 18 HEALTH LAWYER 31, 31-32 (2006).

[13] 42 C.F.R. § 412.52 (2006); Rappeport, *supra* note 8.

[14] FINANCING THE FUTURE REPORT 4, *supra* note 6, at 3.

[15] Craig E. Holm & Alan M. Zuckerman, *Profitable Joint Ventures: A Real-Life Approach*, MANAGING THE MARGIN, July 2005, at 1.

a competitor that may infringe upon a new or existing service line. Hospitals often choose a more defensive strategy when forming joint ventures in an attempt to create a synergistic model with a physician group that would ultimately end up a competitor.[16] On the other hand, some hospitals will take a more proactive stance by creating offensive joint ventures, which typically indicates there is no competitive threat that would force the hospital to react to a market change. Typically, the offensive approach marks the hospital's expansion of an existing service line or opening up of services into a new market.[17] Combination joint ventures involve aspects of both a defensive and offensive arrangement where, for example, a hospital may be entering a new market with a new service but will do so with a group of physicians that pose a potential competitive threat to its existing service line or market share.

Regardless of the model adopted, there are many advantages for hospitals and physicians that choose to participate in a joint venture.[18] If the hospital takes the initiative to create a joint venture (a more offensive approach), many advantages may follow. For example, taking the leadership role in the negotiations can provide the hospital more leverage with which to influence the terms and tone of the discussions in developing the relationship. A more proactive stance may allow the hospitals to retain majority control over the fate of the venture. Further, if the hospital is tax-exempt, then the joint venture can be structured to preserve the hospital's nonprofit and tax-exempt status.[19]

From the physicians' point of view, joint ventures are a favorable business model that allows them the ability to supplement or stabilize what has been for many physicians, declining income and reimbursement rates. Further, by participating in the joint venture, physicians are empowered to play a more meaningful role in the management and operation of a hospital service line.[20] In an effort to be "partnership" minded, physicians are often willing to accept a minority or equal ownership in a joint venture, as they understand that hospitals are better able to handle the regulatory, reimbursement, and tax issues that will be critical to the success of the business. Ultimately, hospitals seek to obtain services through "under arrangements," "provider based," or other joint venture relationships expecting that the relationship with their physician partners will enhance the quality of the services, control costs, and increase efficiency that will help keep their organizations competitive. Additionally, hospitals see potential joint ventures as an opportunity to bring new services to the community and provide access to capital from outside investors (e.g., physician groups) that is necessary to purchase new equipment that will eventually enhance patient care.

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[16] Boettinger & Young, *supra* note 10, at 37; *see also* Holm & Zuckerman, *supra* note 15, at 3.

[17] FINANCING THE FUTURE REPORT 4, *supra* note 6, at 3.

[18] Boettinger & Young, *supra* note 10, at 36-37.

[19] *Id.* at 39.

[20] FINANCING THE FUTURE REPORT 4, *supra* note 6, at 3.

### *B. Enhancing Health Care Quality by Integrating Physician Expertise*

From a clinical quality perspective, a joint venture with physicians is a valuable arrangement because the physicians can contribute significant technical expertise and clinical focus which, in turn, places the business arrangement in a position to have a greater chance for success.[21] Additionally, physicians can have a positive impact on operational effectiveness and regulatory compliance by improving patient throughput (total number of patients cared for in a given period of time), productivity, sourcing and utilization of supplies, and coordinating of clinical personnel needs.[22] If the joint venture is designed properly, the different skill sets the physicians and hospitals possess regarding operations and management can complement each other creating an organization well-positioned to better serve the community. An example is illustrated by a group of physicians who collaborate with a hospital to manage an outpatient surgery center. If the physicians and hospital, working together, are successful in reducing the operating room turnover time and reducing surgical supply utilization, a win-win model has been created. Not only is the hospital's bottom-line improved, but the increased productivity and efficiency paves the way for increased patient satisfaction.[23] The benefit of having physicians in a leadership and management role is that the entire joint venture team is keenly focused on the entire clinical practice, which leads to incentives to improve quality and reduce operational costs. At the same time, health care services are being provided that otherwise might not have been possible had the joint venture not been created.

### *C. Increasing Physician Management Capacity*

Hospitals will occasionally enter into a joint venture agreement with a physician-led group to provide management oversight for a defined set of activities for the hospital (e.g., surgery or a catheterization lab). This management service agreement may involve physician and non-physician investors who are typically service line experts.[24] Utilizing physicians who have the fundamental knowledge of day-to-day hospital operations brings an understanding of clinical practice that can be easily applied to improve quality and efficiency of care. For example, standardization of supplies and equipment and control of staffing numbers are common areas where physicians are able to make significant contributions to right-sizing inventory and personnel. A physician-led management team will often be more aware of what actions are necessary to

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[21] Pizzo & Redd, *supra* note 11, at 82-83.

[22] *Id.* at 83.

[23] *Id.* at 82-83.

[24] *Id.* at 82.

ensure the staff performs at the highest level possible.[25]

Health care industry leaders recognize the impact a vested physician group can play in making a hospital system more efficient. During a Senate Homeland Security and Government Affairs Committee hearing on the competitive effects of specialty hospitals, John Thomas, Baylor Health Care System's former Senior Vice President and General Counsel noted, "[E]conomic investment motivates physicians to bring their time, energy and talent to the design, operation and governance of more effective and efficient health care facilities."[26] Mr. Thomas also testified that the physician efforts led to his facility being among one of the highest rated heart programs in the United States, noting an elimination of $12 million of costs to provide services before the heart hospital was even opened. Further, Mr. Thomas testified about other efforts in his facility to retain key personnel stating that "staff turnover is less than 11% per year, while the rest of our system exceeds 20%."[27] Decreasing turnover can lead to huge cost savings not only in replacing and retraining a new hire, but in ensuring continuity of care for patient teams is not disrupted, which can directly affect patient care and satisfaction.[28]

### *D. Expanding New Services and Purchasing New Equipment*

Joint ventures also provide opportunities for hospitals to expand existing services or, as is sometimes the case, introduce new services to the community. For example, a hospital system in Indiana was working toward replacing an existing facility when a for-profit company began offering physicians in the area partnership opportunities. Using an "under arrangements" joint venture, the hospital was able to move forward to replace its facility and expand the services available in its ambulatory surgery center and heart center. In this scenario, the hospital was not the only one who benefited from the joint venture; the physicians were offered the opportunity to invest in tax-exempt bonds, providing needed capital to the hospital. Although the physician investment created an acceptable level of investment risk that would not be misconstrued as a sham investment, they were still able to legitimately receive relatively high tax-exempt interest rates.[29] In addition, the hospital provided management and

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[25] *An Overview of the Competitive Effects of Specialty Hospitals: Hearing before S. Comm. on Homeland Security and Government Affairs, Fed. Fin. Mgmt., Gov't Information and International Security Subcomm.*, 109th Cong. 3, 5 (2005) (statement of John T. Thomas, Senior Vice President, General Counsel, Baylor Health Care System) [hereinafter *Competitive Effects of Specialty Hospitals*].

[26] *Id.* at 4-5.

[27] *Id.*

[28] *Id.* at 5 (noting that to replace a registered nurse at Baylor is close to $60,000 per nurse for recruiting, training, and retention).

[29] HEALTHCARE FIN. MGMT. ASS'N, FINANCING THE FUTURE II REPORT 2: JOINT VENTURES WITH PHYSICIANS AND OTHER PARTNERS 12 (2005) [hereinafter FINANCING THE FUTURE REPORT

payment incentives that encouraged the physicians to meet quality and efficiency targets, which helped improve the financial standing of the hospital while also benefiting the physicians and the community.

With the cost of medical devices and pharmaceuticals dramatically increasing in the past few years, hospitals and physicians have responded by entering into financial relationships in which both share the burden to subsidize the increased costs.[30] Whether through the purchase of newer, more powerful medical devices or by providing additional units to increase capacity, many hospitals have realized that pursuing a joint venture that requires physician capital investment can ultimately create a reliable partner in building and sharing the risks of creating a successful business venture. Likewise, physicians have realized that partnering with hospitals no longer leaves them shouldering the financial burdens alone or tied to an economic model that may not lead to success without the help of a larger hospital. If, for example, a certain medical device is limited in supply and is very expensive, it is unlikely that the hospital will purchase the device without obvious market signs that such an investment is worthwhile. Through a joint venture, however, a hospital is more likely to invest in the device when physician expertise is utilized as part of an overall market analysis and strategic plan.[31]

### *E. Other Benefits of Joint Ventures*

Generally, the joint venturing of physicians with a hospital brings additional economic benefits to the community. As mentioned above, the new infusion of capital can be used for new equipment, but the possibilities for additional health care improvements do not end there. With the additional investment and influence that the physicians bring to the joint venture, other resources can be redeployed by the hospital to meet any number of needs. An example of this community benefit is demonstrated by the Baylor Health Care System. As Lydia Jumonville, the Senior Vice President and Chief Financial Officer explained, the physician-hospital partnership provided "the opportunity to offer other advantages, such as our employee benefits program, economies of scale in purchasing equipment and supplies, and managed care contracting."[32] Through the joint venture, the health care system realized additional downstream benefits to the hospital employees. The increased purchasing power created by the new joint venture allowed the hospital to negotiate more favorable terms with different managed care providers and equipment vendors, which in turn allowed for the hospital to save dollars that would have been duplicated in other areas of the health care delivery system.

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[30] Pizzo & Redd, *supra* note 11, at 81.

[31] Jonathan M. Joseph, *Hospital Joint Ventures: Charting a Safe Course Through A Sea of Antitrust Regulations*, 13 AM. J.L. & MED. 621, 622 (1988).

[32] FINANCING THE FUTURE REPORT 2, *supra* note 29, at 22.

### *F. Recruitment of New Physicians and Keeping Services Alive in the Community*

Physician recruitment is a topic that extends beyond the discussion of this Article; however, joint ventures offer unique opportunities for a community to support physician recruitment and retention. Often the prospects of a joint venture with revenue sharing opportunities and state-of-the-art facilities present an attractive package to physicians who are considering different practice options and locations. Further, many physicians recognize that a joint venture represents a significant investment in the community. The physicians will share in the benefits and risks and, therefore, are motivated to enhance the quality of care provided to their patients. By having the entrepreneurial opportunity to invest in a new service in a community, the community benefits from the direct involvement of physicians in the ownership and operations of the respective service line.

Furthermore, joint ventures may present a unique practice model for health services that otherwise would have been discontinued in a community. While most joint ventures are created to maximize returns on investment, many such business arrangements ultimately subsidize charity care in other hospital service areas that may be losing money and often provide direct care to the poor and uninsured who otherwise would not have access to care for such services in the community. As John Thomas testified before the Senate Homeland Security and Government Affairs Committee,

> [T]he nation's trauma system is the backbone of effective response to future incidents, if any. There are less than 200 level 1 and 2 designated trauma hospitals in the United States. Baylor has used alignment of physicians, through specialty hospital and ambulatory surgery center joint ventures, and other forms of effective alignment, to keep physicians engaged in the trauma system.[33]

The aforementioned scenario demonstrates that joint ventures present a viable model that impacts health care on many levels. Joint ventures ensure that physicians have an opportunity to fully engage in every aspect of providing and managing care, particularly in specialty areas that are critical to protecting the well-being and health of entire communities.

## III. LEGAL CONSIDERATIONS OF JOINT VENTURES

In addition to reimbursement considerations, there are many laws and

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[33] *Competitive Effects of Specialty Hospitals*, *supra* note 26, at 5-6 (statement of John T. Thomas, Senior Vice President, General Counsel, Baylor Health Care System).

regulations that govern joint ventures. For purposes of this Article, the most significant laws are the federal Anti-Kickback laws, the Physician Self-Referral Law, and the Civil Monetary Penalty provisions. In addition, there are significant tax issues related to a Hospital's exempt status that must also be examined. These laws and tax implications often apply at both the federal and state level and have the potential for creating both civil and criminal penalties if violated.

### *A. Stark Law*

The Physician Self-Referral Law (hereinafter "Stark") prohibits physicians or family members who have a financial relationship with a health care entity from referring Medicare or Medicaid patients to that entity for the provision of certain Designated Health Services ("DHS") unless the arrangement fits within one of the specifically enumerated exceptions.[34] Because DHS include all hospital inpatient and outpatient services,[35] it is very likely that an analysis will need to be undertaken to determine whether Stark will apply because many of the services that will be provided "under arrangements," or through some other joint venture model, are either hospital inpatient or outpatient services.

Services offered on an "under arrangements" basis or pursuant to the "provider based" rules must satisfy at least one Stark exception. Because Stark is very close to a strict liability law, failure to fully comply with any part of the exception leaves one at risk for various legal liabilities. There are three Stark exceptions that are commonly applied to provide protection for joint venture relationships: 1) personal service arrangements; 2) fair market value; and 3) indirect compensation arrangements.

#### *1. Personal Service Arrangements*

In order for the personal services arrangement exception to apply, the parties must agree to the arrangement prior to formation of the joint venture. The agreement must be memorialized in a signed writing which specifies the services that are to be covered.[36] Additionally, the arrangement's term must be for at least one year and the contract for services may not exceed what would be reasonable or necessary to advance the legitimate business purpose of the arrangement.[37] If the arrangement is terminated prior to the completion of the initial year, the parties are not allowed to enter into the same or a similar arrangement for the remainder of the original one-year term.[38] The compensation for the services provided must be set in advance and be based on fair market

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[34] *See* 42 U.S.C. § 1395nn (2000).
[35] *Id.* § 1395nn(h)(6)(K).
[36] 42 C.F.R. § 411.357(d)(i) (2007).
[37] *Id.* § 411.357(d)(iii).
[38] *Id.* § 411.357(d)(iv).

value.[39] The services to be provided cannot involve "the counseling or promotion of a business arrangement or other activity that violates any State or Federal law."[40] Finally, unless the arrangement is a physician incentive plan, the compensation cannot take into account the volume or value of any referral or other business generated.[41]

*2. Fair Market Value*

The conditions of the fair market value exception to Stark are similar to those of the personal service arrangement exception. The fair market value exception applies to any physician or group of physicians arranging to provide items or services to the entity.[42] The arrangement between these parties must be documented in a writing, signed by the parties, and be intended to cover only identifiable items or services.[43] Unlike the personal service arrangement exception, the fair market value exception dictates no set period of time as the minimum required contract duration and permits the inclusion of a termination clause.[44] The fair market value exception applies so long as only one arrangement for the same or similar services is entered into during the course of one year.[45] Any arrangement that is for less than one year may, however, be renewed repeatedly and without limitation, provided the terms and compensation remain the same.[46] Like the personal service arrangement exception, the compensation must be set in advance, must be consistent with fair market value, and cannot be determined by reference to the volume or value of the referrals.[47] Lastly, the arrangement must be commercially reasonable, further the legitimate purpose of the business, and not violate Anti-Kickback or any other federal or state laws.[48]

*3. Indirect Compensation Arrangements*

The third applicable exception, an indirect compensation arrangement, contains requirements similar to those of the previous two exceptions. For example, if physicians owned the management company that provided services to the hospital, then an "indirect compensation arrangement" exception might be the applicable Stark exception. The indirect compensation received by the re-

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[39] *Id.* § 411.357(d)(v).
[40] *Id.* § 411.357(d)(vi).
[41] *Id.* § 411.357(d)(vi)(2).
[42] *Id.* § 411.357(l)(1).
[43] *Id.* § 411.357(l)(1).
[44] *Id.* § 411.357(l)(2).
[45] *Id.* § 411.357(l)(2).
[46] *Id.* § 411.357(l)(2).
[47] *Id.* § 411.357(l)(3).
[48] *Id.* § 411.357(l)(4)-(5).

ferring physician must be at fair market value for services actually provided and cannot take into account the volume or value of referrals.[49] In addition, the arrangement must be set out in writing, signed by the parties, and specify the services covered by the arrangement.[50] An exception applies in the case of a bona fide employment relationship between an employer and an employee, which does not require the arrangement to be set out in a written contract.[51] In the case of a bona fide employment relationship, however, the arrangement "must be for identifiable services and be commercially reasonable even if no referrals are made to the employer."[52] Finally, the arrangement must not violate Anti-Kickback or any federal or state laws.[53]

### *B. Anti-Kickback*

The Anti-Kickback provisions of the Medicare and Medicaid fraud and abuse laws state that an individual will be guilty of a felony if he "knowingly and willfully solicits or receives any remuneration . . . directly or indirectly . . . in return for referring an individual" for the furnishing or arranging of any item or service for which payment may be made under Medicare or Medicaid.[54] Unlike Stark which imposes strict liability, in order to violate the Anti-Kickback statute, there must be both some remuneration offered, paid, solicited, or received and some "illegal intent" on the part of the parties to induce referrals of Medicare or Medicaid.[55] Because the Anti-Kickback statute is not a strict liability statute, full compliance with an Anti-Kickback safe harbor provision is not required. However, the payment for services in an "under arrangements" or other joint venture relationship will constitute "remuneration" under the Anti-Kickback statute, and therefore, it is essential that none of the participants in the joint venture have an illegal intent to induce referrals. If this illegal intent is present, the parties must not proceed with the formation of the joint venture. Even if no illegal intent is present, however, a judge or jury could erroneously conclude that the requisite "illegal intent" is present. Risk related to Anti-Kickback can never be completely eliminated without fully complying with a safe harbor, making it desirable to have the contract structured so that it complies with a safe harbor.

One such safe harbor that could apply to a joint venture is the Investment Interest Safe Harbor. This safe harbor is broken down into three parts depending on the size of the entity and the amount of control possessed by the inves-

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[49] *Id.* § 411.357(p)(1).
[50] *Id.* § 411.357(p)(2).
[51] *Id.* § 411.357(p)(2).
[52] *Id.* § 411.357(p)(2).
[53] *Id.* § 411.357(p)(3).
[54] Social Security Act, 42 U.S.C. § 1320a-7b(b)(1) (2000).
[55] *See id* § 1320a-7b(b).

tors.[56] The three categories, however, exclude from the definition of remuneration "any payment that is a return on an investment interest, such as a dividend or interest income, made to an investor as long as" the standards within that category are met.[57] In addition, four other safe harbors or exceptions could apply to a joint venture of this kind.

*1. Space Rental*

The space rental safe harbor excludes from the term "remuneration" any payments made by a lessee to a lessor for the use of property as long as certain standards are met.[58] These standards include the requirement that the lease agreement be set out in writing, specify the premises covered by the lease, and be signed by the parties.[59] If the lease provides access for only intervals of time and not on a full-time basis, it must specify "the schedule of the intervals, their precise length, and the exact rent for such intervals."[60] The lease term must last for at least one year, and the rental charge for the premises must be set in advance, must be consistent with fair market value, and must not take into account the volume or value of any referrals.[61]

*2. Equipment Rental*

As long as the same standards that were required for the space rental safe harbor are met, this safe harbor excludes from the definition of remuneration any payments made by a lessee of equipment to the lessor of the equipment for the use of the equipment.[62]

*3. Personal Services and Management Contracts Exception*

This safe harbor excludes from the definition of remuneration "any payment made by a principal to an agent as compensation for the services of the agent" if certain standards are met.[63] These standards are very similar to the space rental and equipment rental safe harbors except that they also require that the services performed not promote a business arrangement that violates federal or state law and are not in excess of what would be reasonably necessary to accomplish the business purpose.[64]

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[56] *See* 42 C.F.R. §1001.952(a) (2006).
[57] *Id.*
[58] *Id.* § 1001.952(b).
[59] *Id.* § 1001.952(b)(1)-(2).
[60] *Id.* § 1001.952(b)(3).
[61] *Id.* § 1001.952(b)(4)-(5).
[62] *Id.* § 1001.952(c).
[63] *Id.* § 1001.952(d).
[64] *Id.* § 1001.952(d)(6)-(7).

*4. Per-Click Arrangements*

Since a "per-click" or "per-patient" compensation method is not considered "volume or value" based compensation under Stark, payment on a "per-click" basis is expressly permitted. Regardless of this fact, however, the Office of Inspector General ("OIG") has issued two statements on "per-click" arrangements that indicate a more skeptical view.[65] In a 2003 Advisory Opinion, an unidentified company proposed to develop and manage inpatient rehabilitation units within general acute care hospitals pursuant to certain management agreements.[66] The compensation was to be a monthly management fee calculated on a per patient, per day basis.[67] The OIG responded unfavorably by stating that a payment structure such as this is "disfavored" under the Anti-Kickback statute.[68] Similarly, the commentary of the Anti-Kickback Final Rule includes a discussion clarifying the use of a "per-use" or "per-order" payment arrangement.[69] The OIG questioned this method because of its relationship to volume of business or amount of revenue, which would result in an incentive to refer. However, the OIG did not declare it a *per se* violation of the Anti-Kickback statute, instead stating that the "more the payments appear to reflect the volume of referrals from a financially interested party, the more suspect the arrangement becomes," and that will result in a more thorough analysis by the OIG.[70]

A "per-click" method falls within a gray area of the Anti-Kickback statute. Though the use of a "per-click" may not be a *per se* violation of the Anti-Kickback statute, using this type of agreement will result in the arrangement not complying with the requirements of a safe harbor. Therefore, in order to minimize the risk of a violation, hospitals must look to satisfy as many of the safe harbor's elements as possible. In addition, the parties should establish a number of "good facts" to support the use of "per-click" compensation and to demonstrate that the hospital and physicians have a lawful motive. Some "good facts" might include that the venture raises needed capital to improve services, shares evenly the risk inherent in developing a new delivery model, or results in the pooling of diverse expertise to benefit the overall quality and efficiency of the service provided.

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[65] *See* 3 Op. Off. Inspector Gen. 8 (Apr. 3, 2003), *available at* http://oig.hhs.gov/fraud/docs/advisoryopinions/2003/ao0308.pdf [hereinafter Op. Off. Inspector Gen.]. *See also* Medicare and State Health Care Programs: Fraud and Abuse; OIG Anti-Kickback Provisions, 42 C.F.R. pt. 1001 (2007), *available at* http://oig.hhs.gov/fraud/docs/safeharborregulations/072991.htm [hereinafter OIG Anti-Kickback Provisions].

[66] Op. Off. Inspector Gen., *supra* note 65.

[67] *Id.*

[68] *Id.* at 5.

[69] OIG Anti-Kickback Provisions, *supra* note 65.

[70] *Id.*

### *C. Hospital's Tax-Exempt Status*

There are significant tax issues that may affect the exempt status of a tax-exempt hospital that enters into an "under arrangements" or other joint venture relationship.

#### *1. Private Inurement and Private Benefit Prohibitions*

A tax-exempt entity must ensure that the community, not any individual, receives the benefits of its tax-exempt statutes. Failure to do so can lead to the revocation of the hospital's exempt status. To mitigate these risks, all dealings between the tax-exempt hospital and physicians must be at fair market value and commercially reasonable.

#### *2. Sale of Revenue Stream Arrangements*

Care must be taken to ensure that the joint venture relationship does not result in the sale of a "revenue stream" as described in General Counsel Memorandum 39862.[71] This Memorandum issued by the IRS states that a tax-exempt entity cannot sell its revenue stream.[72] These arrangements are considered to violate the private inurement and private benefits prohibition noted above. A critical element of the joint venture relationship must be that the physicians, directly or indirectly (e.g., through ownership in a management company), are providing bona fide services. This is critical to establish that the arrangement is not the "sale" of a revenue stream but rather a contract for the hospital to purchase bona fide services, at fair market value, from the physicians.

#### *3. Use of Bond Financed Property-Revenue Procedure*

If operations are to be undertaken in a space (or with equipment) that was built or purchased with proceeds derived from tax-exempt financing (e.g., tax exempt bonds), then the operations must be structured to avoid converting the use of that space (or equipment) to "private use."[73] Revenue Procedure 97-13 provides a safe harbor that should be met unless the financed space and/or equipment falls within the "de minimus" amount of private business use that is permitted.[74] If there is excess private use, then the interest income that is paid to bond holders may be subject to taxation as income.[75]

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[71] I.R.S. Gen. Couns. Mem. 39,862 (Nov. 22, 1991).
[72] *Id.*
[73] 26 U.S.C. § 145(a) (2000).
[74] Rev. Proc. 97-13, 1997-1 C.B. 633.
[75] *Id.*

*4. Unrelated Business Income*

The extent and consequences of potential unrelated business income should be considered. Similarly, the potential impact of the joint venture on the hospital's tax-exempt status (e.g., Rev. Rul. 98-15) must be considered.[76]

*5. Fair Market Value Opinion*

A credible third-party opinion is important to help prove the arrangement is at fair market value and commercially reasonable. In order to comply with the requirements of the Anti-Kickback statute, the Stark law, and tax code, it is necessary to establish that the arrangement will result in payment, directly or indirectly, at fair market value.

### *D. Civil Monetary Penalty*

A hospital cannot make payments directly or indirectly to a physician as an inducement for reducing or limiting services.[77] This reflects the statute implicated in the "gainsharing" arrangement on which the Office of Inspector General opined in 2006.[78] Any joint venture relationship that involves managing supplies of staff or other goods or services provided to Medicare and Medicaid patients must be structured so that the hospital is not paying money as an inducement to the physicians to reduce services.

## IV. OPERATIONAL AND QUALITY EFFICIENCY INCENTIVES FOR USE IN BILLING "UNDER ARRANGEMENT" RELATIONSHIPS

Despite the number of legal considerations that one must understand and navigate when structuring the joint venture relationship, there are many other incentive options that can be used to improve the quality, efficiency, and safety of the venture. These incentive options fall under two broad categories: Operational Efficiency Incentive Compensation and Quality of Services Incentive Compensation. As the names suggest, the former category involves behind-the-scenes aspects of the venture, which include the utilization of the materials and equipment of the venture, scheduling of patients, and processes for keeping the venture running at its optimal state. The latter category deals with incentivizing the service aspect of the venture, which helps to provide the patient with a safe, enjoyable, and comfortable experience. Below are a number of incentives that

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[76] Rev. Rul. 98-15, 1998-12 I.R.B. 6.

[77] 42 U.S.C. § 1320a-7a(b) (2000).

[78] 6 Op. Off. Inspector Gen. 2 (Nov. 16, 2006), *available at* http://oig.hhs.gov/fraud/docs/advisoryopinions/2006/AdvOpn06-22NewA.pdf (referring to Rule 14.4).

can be implemented to improve safety, quality, and efficiency within a joint venture relationship.

### *A. Operational Efficiency Incentive Compensation*

#### *1. Inventory Turns*

First, keeping inventory to minimum levels will have a positive effect on the cost, and in some cases, the quality, of the care provided. Second, this incentive, through managed care negotiations and other market forces, is expected to improve the operation of the "central supply" function of a hospital, reduce operating costs, and produce savings that will benefit consumers. Finally, this incentive will promote utilization of the latest in technology and equipment. It has been established that there is a linear relationship between efficient levels of inventory and volume. Therefore, this metric will not be more easily achieved with greater volume. Rather, achieving this metric will depend solely on efficient inventory management. The levels of inventory are designed to promote efficient inventory utilization, and therefore, safeguards may be necessary to protect against inappropriately low levels of inventory. Payments could be made as follows:[79]

| **Range Floor** | **Range Ceiling** | **Payment** |
|---|---|---|
| 0 inventory turns | < 8 inventory turns | $0(%) |
| 8 inventory turns | <10 inventory turns | $X (33%) |
| 10 inventory turns | <12 inventory turns | $X+ (66%) |
| 12 inventory turns | ∞ | $X++ (100%) |

#### *2. First Case On-Time Start*

This incentive promotes physician and patient satisfaction because it creates an environment where surgery schedules are more predictable. In addition, it should reduce operating costs (e.g., less overtime) by producing savings that could benefit patients and other consumers through managed care negotiations and other market forces. A patient case is considered to be started "on time" if the procedure begins no later than an agreed upon number of minutes after the scheduled start time. This metric is unaffected by volume of work. In the alternative, payments could be based upon a percentage increase in on-time starts. Payments can be made as follows based on the percentage of *first* cases of the day being on time or based on the starts of *each* case throughout the day:

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[79] Please note that the tables included in this Article are merely examples and do not necessarily reflect the way in which a specific arrangement will be structured; the Xs indicate a field where an appropriate compensation amount would be inserted, depending on the fact-specific situation.

| Range Floor | Range Ceiling | Payment |
|---|---|---|
| 0% of cases | < 60% of cases | $0(0%) |
| 60.1% of cases | < 75% of cases | $X (33%) |
| 75.1% of cases | < 90% of cases | $X+ (66%) |
| 90.1% of cases | 100% | $X++ (100%) |

*3. Room Turnaround Time*

This incentive should reduce operating costs and produce savings that could benefit consumers through managed care negotiations and other market forces. In addition, the incentive will help to increase volume and lower cost per case. The incentive can be measured from the completion of a procedure to the commencement of the next procedure, which does not take into account the volume or value of work. Appropriate benchmarks should be determined based on literature or other appropriate means, so as not to encourage inappropriate or excessive expense cutting. Payments can be made based on the average room turnaround time:

| Range Floor | Range Ceiling | Payment |
|---|---|---|
| > 30 minutes | None | $0(0%) |
| > 25 minutes | 30 minutes | $X (33%) |
| > 20 minutes | 25 minutes | $X+ (66%) |
| None | Less than 20 minutes | $X++ (100%) |

*4. Utilization of Block Schedule*

If block scheduling is utilized at the hospital or other surgery facility, then incentives can be implemented to ensure that the time is fully utilized and that the operating rooms are not idle while fully staffed. Block scheduling utilization measures how effectively physicians are using scheduled procedure rooms. An incentive plan based on the effectiveness of a physician's utilization of facilities and resources could be structured as follows:

| Range Floor | Range Ceiling | Incentive |
|---|---|---|
| 0% Utilization | < 55.0% Utilization | $0(0%) |
| 55.1% Utilization | 57.5% Utilization | $X (33%) |
| 57.6% Utilization | 60.0% Utilization | $X+ (66%) |
| > 60.0% Utilization | 100% Utilization | $X++ (100%) |

For example, a four-hour time block scheduled in a procedure room has 240 minutes of capacity. If a physician uses 200 minutes of the block time, the utilization percentage is 83%. If the amount of the incentive or compensation is One-Hundred Dollars ($100.00), for example, then according to the chart, the

physician would receive 100% of that amount, or $100.00, because he or she achieved a utilization percentage of more than 60%.

*5. Patient Discharge*

Incentives based upon the percentage of patients that are discharged between specified time periods are also possible and will improve the efficiency of the patient discharge process.

### *B. Quality of Services Incentive Compensation*

*1. Core Measures for Acute Myocardial Infarctions*

The hospital will work with the physicians (e.g., cardiologists) to establish measures and appropriate levels of compliance with those measures (e.g., giving aspirin or beta blockers on arrival or on discharge). The use of this incentive would not take into account the volume or value of the work and should enhance the quality of the services performed. In addition, the data gathered can be used to prove quality and further develop best practices.

*2. Congestive Heart Failure Core Measures*

The hospital will work with the physicians (e.g., cardiologists) to establish quality measures and appropriate levels of compliance to ensure that the hospital is within the top decile on the National Voluntary Hospital Reporting Initiatives for Congestive Heart Failure ("CHF") Core Measures (e.g., discharge instructions and smoking cessation). The use of the core measures will be used to enhance the quality of the services performed as well as to develop reliable data to prove the quality of the services. In addition to the CHF Core Measures, other objective, measurable quality criteria are available from organizations such as Leap Frog and the Centers for Medicare and Medicaid Services.

*3. Patient Satisfaction*

One incentive method that can be used to improve the quality of services provided is to measure and pay incentives to achieve a certain level of patient satisfaction. The incentive would be structured in a way that the joint venture would be required to meet a certain level of patient satisfaction in order to receive compensation. Patient satisfaction could be measured by routine surveys showing patients' "overall satisfaction" with their hospital experience, administered by the hospital or a third-party. For example, if a certain percentage (e.g., greater than 95%) of the patients rated their experience "good" or "very good," the contracted individuals would receive an agreed upon payment as compensation. If the patients rated it lower (e.g., 90.1%-95%), then the compensation would be lower and so on until there would be no compensation provided.

*4. Associate and Physician Satisfaction*

Employees and physicians who are satisfied and comfortable in their positions provide more accurate and efficient assistance to the joint venture. One method of measuring and improving employee and physician satisfaction is through incentives based on the level of satisfaction. If the joint venture efforts result in high levels of employee satisfaction, then it would be entitled to the incentives indicated for that level of satisfaction. Routine satisfaction surveys, retention levels, or comments could measure the level of satisfaction.

*5. Time Out/Universal Protocol Compliance*

This option is used to provide an incentive to attain a minimum compliance level (e.g., greater than 95% or another percent depending on historical data) with respect to The Joint Commission's "Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery."[80] Compliance with The Joint Commission's Time Out/Universal Protocol Compliance of greater than 95%, but less than 100%, would entitle the physicians to the payment as an incentive. The standards could be as follows:

| **Compliance Range Floor** | **Percent of Incentive Pool Available** |
|---|---|
| < 95% | 0% |
| 95% to 95.9% | 75% |
| 96% to 96.9% | 80 % |
| 97% to 97.9% | 85% |
| 98% to 98.9% | 90% |
| 99% to 99.9% | 95% |
| 100% | 100% |

*6. Other Outcome Measures*

Alternative outcome measures of the quality of services could include counting the number of infections (determined from medical record review), redo operations (determined from medical record review), or accuracy of instrument sets (determined by incident reports). Each outcome measure would require an appropriate benchmark to be determined based on industry literature or

[80] The Joint Commission, Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery, http://www.jointcommission.org/PatientSafety/UniversalProtocol (last visited Oct. 14, 2007).

other appropriate means. These alternative outcome measures will seek to improve safety, quality, and efficiency.

## V. CONCLUSION

The use of operational and quality efficiency incentives in joint ventures between hospitals and physicians are tools that can help a hospital provide better overall health care to the community. Among other things, joint ventures provide access to capital, help keep services available to the community, and provide better supervision and control over employees within the hospital. In addition, joint ventures provide physicians with management responsibilities that will improve the overall operation of a hospital. In turn, this will enhance the quality of services performed, control costs, increase efficiency, and provide benefits to many other areas of the hospital as well. The legal restrictions that apply to joint venture arrangements of this type will require significant planning and preparation, but as some of the provided incentives demonstrate, compensation arrangements can be established that will result in a mutually beneficial relationship. For this reason, hospitals and physicians can find a common ground with joint venture relationships. Through hospital and physician collaboration, patients will receive care that is more convenient and safe, the public will see benefits to the communities, the physicians will have more influence or control over their work environment (and achieve some measure of financial security), and hospitals will increase their ability to provide the best possible care.