Nothing Ventured, Nothing Gained:

Continued Vitality of Physician and Physician/Hospital Joint Ventures

Jackson Walker, LLP
112 E. Pecan Street
Suite 2100
San Antonio, Texas 78205
(210) 978-7780
# TABLE OF CONTENTS

I. An Overview of the Development of Healthcare Joint Ventures ......................... 1  
   A. Trend Toward Ambulatory Care ......................................................... 1  
   B. Joint Venture Growth and Congressional Response ................................ 1  

II. Joint Venture Analysis: Basic Statutory Background ................................... 2  
   A. The Anti-Kickback Statute ............................................................... 3  
   B. The Stark Statute ............................................................................ 4  
   C. Joint Venture Fraud and Abuse Analysis Chart ................................ 6  

III. Joint Ventures Today .............................................................................. 7  
   A. Traditional Joint Ventures ............................................................... 7  
      1. Ambulatory Surgery Centers ...................................................... 7  
      2. Specialty Hospitals ..................................................................... 9  
         a. Why Joint Venture Specialty Hospitals? .................................. 9  
         b. The MedCath Model .............................................................. 10  
         c. Congressional Pressure on Specialty Hospitals .................... 10  
      3. Imaging Centers ......................................................................... 11  
         a. Radiologist Owned Imaging Centers ....................................... 11  
         b. Non-Radiologist Physician Owned Imaging Centers ............... 12  
         c. Hospital Ownership .............................................................. 12  
   B. Equipment Leases .......................................................................... 13  
      1. Stark Equipment Lease Exception ............................................. 13  
      2. Per Click Formulas ..................................................................... 14  
      3. Fair Market Value ....................................................................... 14  
   C. Time Sharing and Equipment Sharing Arrangements .............................. 15  
      1. Part-Time vs. Full-Time Arrangements ....................................... 15  
      2. Two Leasing Options .................................................................. 16  
   D. Management Agreements ................................................................. 17  

IV. Tax Exempt Entity Considerations ............................................................ 18  
   A. Overview ....................................................................................... 18  
   B. Revenue Ruling 98-15 .................................................................... 19  
   C. Redlands ....................................................................................... 20  
   D. St. David’s ..................................................................................... 21  
      Exempt Organizations Joint Venture Checklist .............................. 21
E. Intermediate Sanctions ................................................................. 22

V. Conclusions .................................................................................. 24

Hypotheticals
Nothing Ventured, Nothing Gained:

Continued Vitality of Physician and Physician/Hospital Joint Ventures

I. An Overview of the Development of Healthcare Joint Ventures

A. Trend Toward Ambulatory Care

Other than the ever increasing costs of care, if there has been a common thread to the healthcare marketplace over the last two decades, it is the move to ambulatory, non-institutional care. A patient undergoing arthroscopic knee surgery in 1985 was likely to spend the night in the hospital. That same patient today would have the surgery performed in a physician-owned ambulatory surgery center, and would be home for lunch.

The movement towards ambulatory care had its origin in government health program reimbursement. Beginning with the Medicare hospital prospective payment system in 1983, and continuing with increased home health payments throughout the 1990’s, Congress through increasing financial rewards (and penalties) has pushed healthcare delivery into outpatient, homecare, and ambulatory settings. The theory of course is that care can be delivered at less cost in an ambulatory setting. Perversely, however, identical procedures sometimes are actually paid more in an ambulatory setting, than when furnished by a hospital.1

Third party payors quickly followed Medicare’s lead. Increased use of capitation contracts by HMO’s during the managed care 1990’s put financial pressure on providers to limit inpatient stays, and deliver less costly outpatient care where feasible to do so. The net result has been that more and more procedures are performed in a non-hospital setting. In addition, the development of more sophisticated technology has enabled practitioners to deliver care in more clinically “appropriate” and less costly settings.

B. Joint Venture Growth and Congressional Response

A predictable result of the move to ambulatory care was the increased development of joint ventures among physicians, and between physicians and hospitals. Joint ventures for imaging centers, surgery centers, home health agencies, laboratories, and other outpatient facilities proliferated in the 1980’s. As those joint ventures increased, the usage of ancillary services by physicians who had a financial relationship with those facilities increased dramatically. In June 1988, Congress instructed the Office of Inspector General (“OIG”) of the Department of Health and

1 Diagnostic imaging is a case in point. Imaging studies are reimbursed either in a hospital outpatient setting under hospital outpatient PPS (HOPPS), or in a free-standing setting under the Medicare physician fee schedule. An MRI of the chest with and without contrast, for example, is paid $361.53 and $329.61, respectively under HOPPS. Those same studies are reimbursed $452.33 and $377.53, respectively, under the physician fee schedule, when performed in a free-standing center. See, Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2003, 67 Federal Register 89,966 (2002).
Human Services to conduct a study on physician ownership of healthcare entities to which the physicians made referrals. The OIG report concluded that patients of referring physicians who owned or invested in independent clinical laboratories received 45% more laboratory services than all Medicare patients in general. The OIG found similar utilization increases associated with compensation arrangements between laboratories and physicians. Those physicians used 32% more laboratory services than all Medicare patients in general.2

Perhaps reflective of the data uncovered in the OIG report, federal spending on Medicare and Medicaid increased three-fold from 1980 to 1990. The federal government spent $49.0 billion on the Medicare and Medicaid programs in 1980. By 1990, that amount had increased to $150.8 billion. 3

Based in part on these factors, in 1989 Congress tried to stem the tide by passing the Ethics in Patient Referrals Act, a/k/a the Stark statute.4 The intent of the law was to reduce over utilization of laboratory services by prohibiting physicians from referring Medicare patients to laboratory facilities in which they or a family member had an ownership or other financial interest. Effective January 1, 1995, Congress expanded the Stark prohibitions to ten other designated health services, including diagnostic imaging, physical therapy, home health, and inpatient and outpatient hospital services.5 The law had an immediate impact, and quickly put a chill into existing and proposed physician ventures. The Stark statute radically shifted the growth path for physician joint ventures, and has helped create full employment for healthcare lawyers.

The industry has adjusted to Stark, however, and despite continued pressure from Congress and federal regulators, joint ventures among healthcare providers continue to proliferate. Hospitals continue to look for ways to partner with physicians and even other hospitals, and physicians are examining ways to provide a broader scope of services to their patients, while legitimately profiting from the business they control. As other sources of revenue shrink for physicians, and new technologies continue to emerge, physicians are looking for opportunities to invest in cutting edge technologies that will benefit their patients, while creating a profitable revenue stream for them. Properly evaluating the risks of such opportunities, and creating solutions for individual clients, is the challenge in health law today.

II. Joint Venture Analysis: Basic Statutory Background

Many state and federal laws affect the ability of healthcare providers to enter into joint venture transactions. State and federal anti-kickback and anti-referral laws, as well as anti-trust laws, govern whether two or more providers can safely do business together. State licensing and certificate of need laws also impact the final “deal.” Reimbursement and patient privacy regulations govern many of the operational aspects of a venture. This paper will focus on the two principal federal laws affecting the overall ability of providers to interact with one another – the Anti-Kickback statute and the Stark statute.

---

5 Pub. L. 103-66, Title XIII, § 13562(a), 107 Stat. 596.
A. The Anti-Kickback Statute

The federal Anti-Kickback statute, 42 U.S.C. §1320a-7b(b), prohibits the offer, solicitation, payment or receipt of any remuneration (directly or indirectly, overtly or covertly, in cash or in kind) which is intended to induce the referral of a patient for, or the purchasing, leasing, ordering or recommending of, items or services reimbursable under Medicare or Medicaid. The federal government has authority to enforce the law through criminal prosecution (a conviction may result in a fine of up to $25,000, imprisonment for up to five years, or both) and through exclusion from participation in Medicare and Medicaid for at least five years if in conjunction with a criminal conviction, or for a period of time determined by the government if as the result of administrative action.

The anti-kickback law was enacted in 1972, with significant amendments in 1977 and 1987. In the years since then, the federal government, acting primarily through the Office of Inspector General (“OIG”) of the Department of Health and Human Services (“HHS”), has broadened its interpretation of the law to prohibit arrangements that did not appear unlawful in the years immediately following enactment of the statute. The OIG’s broad interpretation of the law has been adopted by some courts that have considered it. For example, in U.S. v. Greber, 760 F.2d 68 (3rd Cir. 1985), cert. den., 474 U.S. 988 (1985) the Court held that “if one purpose of a financial relationship is to induce future referrals” (emphasis added), the relationship is prohibited by the anti-kickback law, notwithstanding that the relationship is intended for other permissible purposes as well. Since then, other federal courts of appeals have rendered decisions in criminal cases not substantially different than the holding in the Greber case.6

Thus, a below market lease offered by a hospital to a physician willing to locate in the hospital’s medical office building, if that physician refers patients to the hospital, almost certainly would violate the Anti-Kickback statute because the presumption would be that the intent of the parties was to induce referrals to the hospital through a benefit to the physician of a below market lease. Similarly, extraordinary returns to physician investors who refer patients to an outpatient imaging facility may be construed as remuneration for referrals.

Because the breadth of the anti-kickback law threatened to impede the establishment of bona fide business enterprises for the provision of healthcare services, in 1987 Congress instructed HHS to publish “safe harbor” regulations in order to provide the opportunity for parties to certain categories of relationships to avoid the risk of violating the anti-kickback law. Final regulations were published on July 29, 1991, and are found at 42 C.F.R. Part 1001. Proposals to expand the safe harbor regulations were published on November 5, 1992 (57 Fed. Reg. 52723) and on September 21, 1993 (58 Fed. Reg. 49008). Proposed “Clarifications” to the original safe harbors were published July 21, 1994 (59 Fed. Reg. 37202), and new safe harbors were published on November 19, 1999 (64 Fed. Reg. 63518).

It is by now axiomatic that it is not per se illegal to participate in an arrangement that falls outside the scope of the regulations. The regulations merely define categories of conduct or business relationships that will be exempt from prosecution under the law. With respect to the legality of any

---

6 See U.S. v. Kats, 871 F.2d 105 (9th Cir. 1989); U.S. v. Bay State Ambulance, 874 F.2d 20 (1st Cir. 1989).
A 1993 case sheds additional light on that analysis. In exercising its administrative exclusion authority in a non-criminal case under the anti-kickback law, the OIG interpreted the law to apply to dividend distributions paid by an entity to bona fide investors when the opportunity to invest allegedly was offered in order to induce the investors to refer patients to the entity for services reimbursable under Medicare or Medicaid. That interpretation was upheld by a federal district court in California. *The Office of Inspector General v. Hanlester Network, et al.,* aff’d D.C.C.D. Ca., 1993.

The Ninth Circuit, however, reversed that decision, holding in an important decision for providers, that the anti-kickback law requires that the government must show that the provider(s) “(1) know that [§1320a-7b(b)(2)] prohibits offering or paying remuneration to induce referrals, and (2) engage in prohibited conduct with the specific intent to violate the law.” *Hanlester Network v. Shalala,* 51 F.3d 1390 (9th Cir. 1995)(emphasis added).

A full discussion of the anti-kickback law is beyond the scope of this paper. In summary, however, Counsel must evaluate each aspect of a joint venture, in order to determine the relative degree of risk under the statute. Each financial and contractual connection between the parties should be scrutinized to ensure that goods or services changing hands are being provided at fair market value, and at a level no more than necessary for the business purposes of the arrangement. Overall, the parties should ask whether the transaction is commercially reasonable, even if no referrals were to occur between the parties. (See attached chart at page 6)

**B. The Stark Statute**

The more restrictive of the two “fraud and abuse” laws is the Stark statute. Intended by its author as a “bright-line” test, Section 1877 of the Social Security Act (42 U.S.C. § 1395nn) imposes restrictions upon referrals by physicians to providers of certain designated health services under the Medicare and Medicaid programs. Subject to specified exceptions, the Stark law provides that if a physician (or an immediate family member) has a financial relationship with an entity: (1) the physician may not make a referral to the entity for the furnishing of designated health services reimbursable under the Medicare and Medicaid programs, and (2) the entity may not bill for designated health services furnished pursuant to a prohibited referral. A financial relationship includes ownership or a compensation arrangement.

The Stark law became effective January 1, 1992 for clinical laboratory services (“Stark I”) and January 1, 1995 for ten other designated health services (“Stark II”): physical therapy services; occupational therapy services; radiology services (including MRI, CT scans and ultrasound); radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices; home health services and supplies; outpatient prescription drugs; and inpatient and outpatient hospital services.\(^7\) While intent is a factor considered in relation to the anti-kickback law, an entity’s or a physician’s intent is irrelevant in proving a violation of the Stark law.

---

\(^7\) Pub. L. 103-66, Title XIII, § 13562(a), 107 Stat. 596.
HCFA published the Stark I final regulations on August 14, 1995, and the Stark II regulations on January 4, 2001.8 As with the safe harbor regulations, these rules shed additional light on permitted conduct under the law.

If a financial arrangement between a physician and a DHS entity does not fit into an applicable exception, not only may the services rendered not be billed to Medicare or Medicaid, but all other referrals for designated health services from the physician to the entity become tainted as prohibited referrals. In addition, civil money penalties of not more than $15,000.00 for each wrongfully billed claim may be imposed, and the providers may be excluded from the Medicare and Medicaid programs. Efforts to manipulate the statute (such as cross-referral arrangements) are known as circumvention schemes, and subject the participants to a civil money penalty of not more than $100,000.00 and possible federal health care program exclusion. Claims submitted in violation of the Stark statute and/or the Anti-Kickback statute may also form the basis for liability under the Federal Civil False Claims Act.9

Exceptions applicable to both ownership as well as compensation arrangements between a physician and an entity include the in-office ancillary services exception, the rural provider exception, the hospital ownership exception, and general exception related to ownership in publicly traded securities and mutual funds. If the structure of a proposed venture is a traditional joint venture (see discussion infra at page 7), where the physician has an ownership interest in the entity that actually provides and bills for the designated health services, that ownership interest will have to meet one of the applicable exceptions.

If the physician’s interest in the joint venture is only a compensation arrangement, exceptions exist for contracts such as rental of office space, rental of equipment, employment relationships, personal services arrangements, and physician recruitment. A complete discussion of the applicable ownership and compensation arrangement exceptions is beyond the scope of this paper.

Following is a chart that gives a sample methodology to analyze proposed transactions for Stark and anti-kickback risks. While not an exhaustive analysis, the chart is helpful in creating a “decision tree” that providers and counsel can use in an initial analysis of a proposed venture.

---

8 66 Federal Register 856 (January 4, 2001).
9 In U.S. ex rel Thompson v. Columbia-HCA, a qui tam realtor (i.e. a private person bringing suit on behalf of the government) contended that claims submitted in violation of the Stark law and the anti-kickback law constitute false or fraudulent claims under the False Claims Act. This interpretation of the realtor’s claim, although dismissed at the trial court level, 938 F. Supp. 399 (S.D. Tex. 1996), was eventually upheld by the district court after remand from the Fifth Circuit. 125 F.3d 899 (5th Cir. 1997), on remand. 20 F. Supp. 2d 1017 (S.D. Tex. 1998). Under the Civil False Claims Act, 31 U.S.C. § 3729(a), the knowing submission of a false claim for payment may result in damages of up to triple the amount of damages sustained by the government because of the false claim, as well as a civil penalty up to $11,000.00 for each false claim.
Is there a Referral?

Yes → No Violation

No ← Medicare/Medicaid?

Yes → Analyze State Law

No ← Designated Health Services?

Yes ← Financial Relationship?

No ← Anti-Kickback Analysis

Yes ← Remuneration?

No ← Safe Harbor?

Yes ← Inducement? Intent?

No ← Stark Exception?

Yes ← Stark Violation

No ← Likely Anti-Kickback Violation

No ← Likely Anti-Kickback Violation

Yes ← Analyze State Law

No ← Financial Relationship?

Yes ← Anti-Kickback Analysis

No ← Remuneration?

Safe Harbor?

No ← Inducement? Intent?

Yes ← No Violation

No ← No Violation

No ← No Violation

No ← No Violation

No ← No Violation
III. Joint Ventures Today

Primarily because of the limitations of the Stark statute, and to a lesser degree the Anti-Kickback statute, counsel today has to be much more creative in forming joint ventures that are productive for the clients, while still complying with applicable law. No longer is it simply a question of forming a limited partnership and distributing the profits of the enterprise to the owners. A careful analysis of the applicability of the Stark and Anti-Kickback statutes, as well as relevant billing and reimbursement requirements, ultimately will drive the final structure of the venture. Four of the most common types of ventures are as follows:

A. Traditional Joint Ventures
B. Equipment Leases
C. Time Sharing and Equipment Sharing Arrangements
D. Management Agreements

Each of these models will be examined in turn.

A. Traditional Joint Ventures

A “traditional” joint venture occurs when the parties form a new legal entity, often a limited liability company or a limited partnership, to provide a certain kind of diagnostic or therapeutic service. The new entity is distinct from any of its owners, and often will receive referrals from those owners, as well as other referrals from the community generally. The entity provides and bills for healthcare services in its own name.

With few exceptions, traditional joint ventures can only be utilized for services not subject to the Stark statute. If the venture provides services that are not designated health services under the Stark statute, or if none of the investors are physicians who refer patients to the entity, then the Stark statute will not restrict the transaction. For a limited number of joint ventures that otherwise would be subject to Stark, if an applicable exception exists, the venture may proceed.10

1. Ambulatory Surgery Centers

One of the most common traditional joint ventures is an ambulatory surgery center (“ASC”), which is usually comprised of investors who are surgeons providing services at the center. In many cases, a local hospital is an investor alongside the physicians. Surgical services furnished in an ASC are not designated health services under the Stark statute, and thus Stark typically does not apply. For those few instances when the ASC service includes a designated health service11 a Stark regulatory exception exists. Implants such as IOL’s are excepted from the referral prohibition in the Stark statute so long as (i) the implant is furnished by the referring

10 The rural exception, for example, allows physicians to refer to a DHS entity located in, and primarily serving, a rural area. 42 U.S.C. §1395nn(d)(2).
11 For example, when an ophthalmologist performs cataract surgery, he implants an intraocular lens (“IOL”) in the eye. Because it replaces an “organ” of the body (namely the lens of the eye), the IOL is considered a prosthetic, which is a designated health service.
physician or a member of his group practice in a Medicare-certified ASC, (ii) the implant is implanted in the patient during a surgical procedure performed in the same ASC where the implant is furnished, and (iii) billing for the implant complies with all state and federal laws.\textsuperscript{12}

ASC’s traditionally have had favored status under the Medicare program. As a matter of policy, furnishing surgical services in an outpatient setting is more cost effective and often more convenient for the patient. Moreover, because of the invasive nature of surgical services, Congress and CMS concluded that the likelihood of abuse of such an investment is remote.

Under the Anti-Kickback statute, the OIG published in 1999 a safe harbor for physician investments in ambulatory surgery centers. A similar exception exists for ventures between surgeons and hospitals. The safe harbor for surgeon-owned ASC’s requires, among other things, that all of the surgeon investors have at least one-third of their medical practice income derived from the surgeon’s performance of procedures which can be performed in the ASC.\textsuperscript{13} In addition, several of the standard safe harbor provisions applicable to investment interests in small entities also apply. Thus, the investment opportunity must not be related to the expected volume of referrals generated from the investor; the entity or any other investor must not loan or guarantee funds to the investor; and the amount of return on investment must be proportional to the amount of the capital investment. Finally, any ancillary services provided to Medicare or Medicaid patients at the ASC may not be separately billed to those programs.

The OIG also created an exception for hospital/physician ASC’s, where at least one investor is a hospital, and all of the remaining investors meet the requirements of the physician-owned ASC safe harbor. In addition to those requirements, if the ASC leases space or equipment or any other services from the hospital investor, that arrangement must meet an applicable exception under the Stark statute.

Many ASC’s are phenomenally successful, returning the capital invested in the first year. Because of the ASC favored nation status, and because the ASC safe harbor is relatively easy to comply with, ASC’s remain one of the most profitable and lowest risk joint ventures.

A typical ASC structure between a hospital and selected area physicians would look like this:

\textsuperscript{12} 42 C.F.R. § 411.355(f)
\textsuperscript{13} 42 C.F.R., Section 1001.952(r)(1).
2. **Specialty Hospitals**

Some think that specialty hospitals are just ASC’s on steroids. A specialty hospital actually is a fully licensed acute care hospital that focuses care and treatment usually on one particular specialty, such as cardiology, orthopedics, cancer care, or short stay. While it is fully licensed as a hospital, it is more like an ASC experience for the patients: more outpatient surgeries, and shorter lengths of stay (hence reduced costs) for inpatients. Specialty hospitals are like successful boutique law firms: smaller, more flexible, and designed to provide excellent services only in the specialty selected.

a. **Why Joint Venture Specialty Hospitals?**

The clinical and business answer is that in cardiology and orthopedics particularly, the types of patients treated demand specialized care, often using expensive, technology-intensive procedures. Specially trained nursing staff and ancillary professionals can focus their training and experience in the selected area, resulting in repeatable procedures and more predictable day-to-day quality and outcomes. The subspecialty physicians know they have the option to refer their patients and perform their procedures in any hospital, and this direct control of the referrals gives them an opportunity to be an attractive investment partner for the hospital. The lure of a hospital created just for your specialty is intoxicating for many physicians.

The clinical and business justifications are important. But the real answer is Stark, Stark, Stark. There is nothing new in physicians owning hospitals. Physicians have owned hospitals practically since the beginning of organized medicine. The hospital is simply a setting for an extension of the physician’s practice. Thus, when Congress passed the Stark statute as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA ’89), one of the exceptions contained in the law was for physician investments in a hospital, provided that certain conditions were met. Although the hospital exception was modified slightly in 1993, the basic premise for the exception remained: where the physician’s investment is in the hospital as a whole (and not merely a subdivision or department of the hospital), any profits he may receive for his ownership interest is too attenuated a connection to be thought to be an inducement for referrals for specific hospital services.
The whole hospital exception in Stark merely codified long-standing practice in many communities. That codification, however, created an opportunity for creative and aggressive hospital entrepreneurs. As more and more hospital procedures moved to less expensive outpatient settings, like ASC’s, and as the Stark law continued to eliminate many common physician joint ventures, physicians looked for new investments, and entrepreneurs looked for new, less expensive ways to deliver care. With a built-in exception for hospital ownership, the specialty hospital was born.

b. The MedCath Model

Perhaps the most well known company in the specialty hospital industry is MedCath. Based in Charlotte, North Carolina, MedCath specializes in cardiac care. Founded in 1988 as an operator of mobile and other cardiac catheterization laboratories, MedCath completed an initial public offering in 1994 to raise capital to build its first heart hospital, which opened in 1996. MedCath has developed a total of 10 hospitals, and has begun developing three more hospitals. MedCath management notes they intend to begin development on one to three new heart hospitals each year. There currently are at least three MedCath facilities in operation or under development in Texas.

The MedCath model specialty hospital typically is structured with local referring investor physicians. The structure can be quite complex, but pared down to its essentials, the hospital typically is a limited partnership made up of physician limited partners, and a MedCath controlled entity general partner. The limited partners typically generate the lion’s share of the initial referrals to the hospital, but that percentage reduces over time as the hospital gains recognition and acceptance in the community.

Critics of specialty hospitals claim the facilities merely skim the cream off the top by siphoning off expensive profitable procedures, while leaving sicker, more costly patients in the community hospitals. They argue that specialty hospitals provide no emergency care, and are simply a vehicle for capturing surgeon referrals. Those critics cite a 2003 GAO study which provided data to support the “cherry-picking” claim.14

Proponents counter the cherry-picking claims with private studies that show that specialty hospitals had a case mix index (CMI) in 2001 20% higher than their peer group, which included major teaching hospitals, and a CMI 24% higher than community hospitals.15

c. Congressional Pressure on Specialty Hospitals

The specialty hospital phenomenon may be a thing of the past, however. Amid strong pressure from community hospitals, and criticism from CMS, Congress has indicated its intention to ban future specialty hospitals. The Senate version of the Medicare prescription drug bill, S.1, amends the Stark statute to restrict physician ownership to acute

---

15 A Comparative Study of Patient Severity, Quality of Care and Community Impact at MedCath Hospitals, Al Dobson, PhD., The Lewin Group, May 2003.
care hospitals that offer the “comprehensive spectrum of inpatient and outpatient hospital services.” The effective date of the amendment is January 1, 2004, but it would not apply to hospitals that were “substantially completed” before June 12, 2003. As a result, if the legislation is passed, this change to the whole hospital exception would only impact future specialty hospitals, not those that already exist.

The House version of the bill (H.R. 2743) only provides for a study to be conducted of specialty hospitals to determine if there are excessive self-referrals, whether the quality of care differs from acute care hospitals, the impact of specialty hospitals on acute care hospitals, and the differences in the scope of services, Medicaid utilization, and uncompensated care. Whichever version finally emerges from the conference committee, it seems likely that “specialty” hospitals as an investment vehicle for referring physicians will be severely restricted or eliminated.

3. Imaging Centers

The universe of imaging center joint ventures can probably be divided into three categories:

a. Radiologist owned imaging centers;

b. Non-radiologist physician owned centers;

c. Hospital ownership.

The legal complexities associated with each form of ownership varies proportionately.

a. Radiologist Owned Imaging Centers

Radiologists, pathologists, and radiation oncologists receive special treatment under the Stark law. For the most part, and with limited exceptions, referrals from radiologists to imaging centers in which they have an ownership interest are excluded from the Stark definition of “referral.” Thus, when the physician investors in an outpatient center are limited to radiologists, very few Stark issues arise.

Similarly, the OIG’s interpretation of the Anti-Kickback statute acknowledges that radiologists typically do not make referrals for imaging services. The referrals instead are controlled by the patient’s treating physician, and the OIG has acknowledged that radiologists are unlikely to generate any significant number of referrals to a joint venture MRI center, and thus do not present a significant risk under the Anti-Kickback statute.

Stark and Anti-Kickback questions sometimes can arise in a case of interventional radiologists who actually become the treating physician for the patient

---

16 Another Attack on Specialty Hospitals, Susan Koch and Jed Morrison, Jackson Walker, LLP E-alert (June 20, 2003).
17 See 42 C.F.R. § 411.351.
18 OIG Advisory Opinion 97-5 (October 6, 1997).
and might subsequently order follow-up diagnostic tests. In such cases, an applicable ownership exception must be found. For the most part, though, so long as profit distributions are proportional to the amount of capital invested, and the venture is otherwise a bona fide healthcare provider, few Stark or Anti-Kickback issues are present.

b. Non-Radiologist Physician Owned Imaging Centers

When referring physicians are offered an ownership interest in an imaging center, the first question is to determine whether the venture can comply with the Stark law. The parties must either (i) structure the venture to comply with one of the ownership exceptions in the Stark law, such as the in-office ancillary services exceptions, (ii) limit the services provided in the center to non-designated health services such as PET or nuclear imaging, or (iii) structure the arrangement as a lease agreement or management agreement such that the referring physicians do not actually have an ownership interest in the center.

While compliance with the Stark statute is not tantamount to compliance with the Anti-Kickback statute, if counsel can create a structure that complies with Stark, there ordinarily should be a minimal level of risk under the Anti-Kickback statute. Compensation to the owners, whether under a lease agreement, management agreement or otherwise, of course cannot vary according to the value or volume of referrals of business. Distributions to owners must be proportionate to the amount of capital invested, and the venture should be a bona fide healthcare provider that provides a needed service in the community.

To illustrate that last point, the small entity safe harbor under the Anti-Kickback statute provides protection to joint ventures that, among other things, do not have more than 40% of the investors in a position to make referrals or generate business to the entity, and no more than 40% of the revenues are attributable to such investors.\footnote{42 C.F.R. § 1001.952(a).} As noted previously, failure to comply with the safe harbor does not mean the Anti-Kickback statute is violated. However, if an outpatient imaging center in an otherwise saturated market only survives because of the referrals from its investor owners, such that it never even approaches the 60% non-investor revenues component of the safe harbor, it is very likely the OIG would consider such a venture a mere shell for the benefit of its investing physicians. While such a structure might be compliant with Stark (say if it is formed in a rural area, or does not provide DHS), it would be at risk under the Anti-Kickback statute in such circumstances.

c. Hospital Ownership

Hospital ownership adds still more layers of complexity. The physician owners co-venturing with the hospital now may have an indirect financial arrangement with the hospital. Whether the ASC investment fits into an appropriate Stark exception not only affects the physician’s ability to refer to the imaging center,
but also his ability to refer patients to the hospital for inpatient or outpatient hospital services.

Hospital joint ventures also can implicate the Medicare provider-based regulations. On-campus imaging centers that are not wholly owned by the hospital on whose campus the center is located, nonetheless may be treated as provider based if the parties comply with the provider-based regulations. Typically, obtaining provider-based status results in higher reimbursement for the entity, but as noted at the outset, however, (see page 1, supra), diagnostic services furnished under HOPPS may not always pay more than services provided under the physician fee schedule.

B. Equipment Leases

The Stark statute is applicable to a physician’s ownership interest in an entity, as well as a physician’s compensation arrangement with that entity. The exceptions for ownership interests are very narrow and strictly applied, and if the parties determine that the Stark statute is applicable to their transaction, and they cannot fit the desired business arrangement into an ownership exception, the alternative is to create a compensation arrangement between the parties that produces a similar economic effect. One of the more common compensation arrangements between physicians and entities to which they refer is the equipment lease.

1. Stark Equipment Lease Exception

The equipment lease exception to Stark provides that a physician may refer patients to an entity with which he has a financial relationship, if that financial relationship is an equipment lease that meets all the following conditions:

- The lease agreement is in writing, signed by the parties, for a term of at least one year;
- The equipment rented does not exceed that which is reasonable and necessary, and is used exclusively by the lessee when being used by the lessee;
- Rental rates are set in advance consistent with fair market value, and not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties;
- The lease would be commercially reasonable even if no referrals occurred between the parties.  

A typical lease structure would look like this:

20 See 42 C.F.R. § 413.65(f).
2. **Per Click Formulas**

The concept of calculating a lease payment formula that is not related to the “volume or value of any referrals or other business generated between parties” has generated much discussion in the industry and resulted in a great deal of creativity by counsel for the healthcare providers. The safest and most traditional form of equipment rental payments is the flat monthly fee. So long as the fee is in the range of fair market value, it’s hard to beat the old monthly lease.

But in January 2001, HCFA (hereafter “CMS”) published the Stark II Phase I final regulations.22 Those regulations created significant liberalization in CMS’ view of the meaning of the “volume or value” standard. Citing the legislative history of the original 1989 Stark legislation, CMS concluded that rental arrangements based on per use or unit of service based payments would be protected, so long as the payment per unit is at fair market value and is not otherwise affected in any manner by the amount of designated health services referrals.23

Thus, referring physicians wishing to invest in imaging equipment can form a joint venture equipment company which leases the equipment to the provider of services, either a hospital, a radiology group, or another healthcare provider. According to CMS, so long as the per unit rental rate is equal to fair market value, the referring investors may make as many referrals for imaging services as they wish, and each of those referrals will generate additional income to the equipment company under the lease. CMS made it clear in the preamble to the regulation that per use rental payments would be protected, even for procedures performed on patients referred by the physician/owner.

3. **Fair Market Value**

While the CMS definition of “volume or value of referrals” could imply potentially unlimited referrals by a physician investor to an entity that leases equipment from the investor’s company, the payments in fact are not unlimited. The entire compensation under the lease still has to be fair market value, both under the Stark statute as well as the Anti-Kickback statute.

---

22 66 Federal Register 856 (January 4, 2001).
23 *Id.* at 876, col. 3 (January 4, 2001).
Consider a scenario where the base rental rate for a piece of radiation therapy equipment is $20,000 a month when leased from the manufacturer. A group of physician investors purchases the equipment, and leases it to a hospital. If the parties have agreed that the rental rate would be $100 per procedure, at the point that 100 procedures are performed at the facility, the fair market “baseline” rental would be reached. Because the physician investors are willing to accept the downside risk of the investment, however (if fewer than 100 referrals are generated - a risk the manufacturer would not be willing to accept), then those physician investors certainly could expect some additional upside return above the $20,000 a month. Just what that amount is is a matter of the risk tolerance of the individual investors. It would be hard to imagine CMS objecting to an equipment lease structured as described above, which resulted in $22,000 monthly rental during the busy months. However, if the equipment consistently generated $25,000, $26,000, or $30,000 a month in rental payments, it is very possible that CMS or the OIG could conclude that the initial per unit rate was not calculated at an appropriate amount and that the overall lease transaction is not at fair market value, a violation of both Stark and the Anti-Kickback statute.

In the case cited above, counsel should structure the lease with a cap, so that in “busy” months, the total lease payments would not exceed a fair market value maximum. How high that cap will be is a function of the downside risk assumed by the investors, and the tradeoff upside potential of the investment. Ultimately, it is a question of how well the venturers wish to sleep at night.

C. Time Sharing and Equipment Sharing Arrangements

Many physicians, especially small group practices and sole practitioners, cannot afford expensive diagnostic equipment on a full-time basis. Those parties often wish to structure arrangements whereby they can lease equipment on a part-time basis, either through a direct lease or a time sharing arrangement with other providers.

1. Part-Time vs. Full-Time Arrangements

For physicians seeking an ownership interest in an entity to which they can refer patients for designated health services, the most useful and commonly employed exception in the Stark statute is the in-office ancillary services exception. That exception provides, among other things, that physicians may refer patients for DHS within their practice if the services are furnished in a building in which the referring physician provides healthcare services unrelated to the DHS, or if the services are provided in a centralized building used by the group practice for the provision of its DHS. CMS interprets that provision with respect to equipment leases in the following fashion: If the physician leases DHS equipment in the same building in which he maintains a full-time office for the practice of medicine, he may lease that equipment on a part-time basis. If however, the DHS are provided in a building where the physician does not have an office location (i.e., a “centralized building”), the physician may only lease DHS equipment in that building on a full-time, 24/7 basis. As CMS notes: “Part-time ‘centralized’ DHS arrangements are prohibited. For example, a group practice may not rent an MRI facility one day per week and treat that facility as a “centralized building.”24

Many providers submitted comments to the Stark II Proposed Rule urging CMS to establish a separate regulatory exception specifically for shared facilities. The commenters argued that shared

facilities pose no greater risk of over utilization than DHS furnished by solo practices or group practices. Moreover, shared facilities are likely to be more convenient and efficient for the practice as well as the patients.

CMS disagreed. It concluded that to insure that DHS facilities are truly an extension of the physician’s practice, it would require that physicians wishing to share equipment must be located in the same building as the equipment. CMS appears to be drawing the conceptual distinction that the closer the physical nexus to the physician’s office location, the more clearly an extension of the doctor’s practice, and the more flexibility available for shared usage of the equipment. Where the equipment no longer has that same physical connection to the physician’s office location, and the physician wishes to avail himself of the centralized building option within the in-office ancillary services exception, at that point the equipment must be fully owned or leased by the physician to justify the “extension of practice” treatment.

One can argue whether CMS is really justified in this analysis. It appears to go beyond the strict language of the statute which allows DHS services to be provided in the same building where the physician practices or another building used by the group for the centralized provision of the group’s DHS. The statute makes no distinction about full or part-time equipment leases, yet CMS has drawn a fairly clear regulatory line in the sand. Because courts tend to give substantial deference to the agency responsible for administering a statute, it is likely that CMS’ full-time/part-time distinction would be upheld if ever challenged.

2. Two Leasing Options

Thus, there are two basic scenarios by which physicians could invest in equipment used to provide designated health services, one for personal use, and one as a pure investment. If the physicians are located in the same medical office building, and the equipment also is located in that building, the physicians may jointly own the equipment through a third party equipment company, and that equipment company could lease the equipment to each practice on a part-time basis. Such part-time leases are typically of the Monday-Wednesday-Friday, or three-afternoons-a-week variety, so that each physician lessee has the equipment for a specified period of time. The equipment exception to Stark requires that equipment “is used exclusively by lessee when being used by the lessee” 25 and thus, the parties must at least provide for exclusivity on the face of the lease documents.

The second option for a shared equipment arrangement is for two or more groups of physicians (or even the hospital partner for that matter) to form a separate equipment company to own the necessary equipment. That company would lease the equipment on a full-time basis to one of the venturers, or even to a third party provider not part of the equipment company joint venture. Thus, a radiology group and an orthopedic group might jointly form an equipment company to purchase an MRI. That equipment company then would lease the equipment, supplies and staff to the orthopedic group, and the orthopedic group would bill for the MRI technical services under its own provider number. The radiology group typically would provide the medical direction and the professional interpretation of the studies, and might also provide the appropriate level of supervision for each of the services provided. Since the diagnostic services are being provided by a medical

group rather than an independent diagnostic testing facility (“IDTF”) the physician supervising the diagnostic tests need not be a trained radiologist. Members of the orthopedic group could fulfill the necessary supervision requirements for the MRIs being performed. In cases where the diagnostic services are being provided by a joint venture IDTF, the Medicare regulations require that the supervising physician be one who is trained and certified to perform and supervise such procedures. An orthopedist likely would not meet that requirement.

D. Management Agreements

Where for reasons of state or federal law physicians cannot have an actual ownership interest in the selected venture, and where more than just equipment is being provided, a management agreement joint venture can be a close substitute. The management agreement model is very similar to the equipment company model. A group of physicians wishes to form an entity that could provide certain management and clinical services to the hospital. The entity furnishes such services to the hospital “under arrangement,” thereby enabling the hospital to bill Medicare for the services under its provider number.

Consider a situation where a hospital wishes to open a department to provide hyperbaric oxygen (“HBO”) therapy services to its patients. Certain area physicians and private investors have expertise in operating HBO departments. The physicians and the private investor form a management company whose business is constructing and operating HBO departments for hospitals. The company enters into a management agreement with the hospital to provide turn-key HBO services “under arrangement” to the hospital. The Medicare Hospital Manual provides that hospitals may have others furnish covered items or services to its patients through arrangements under which receipt of payment by the hospital discharges the liability of the beneficiary to pay for the services. The hospital bills for and maintains ultimate responsibility for the services.

Management Company Model

![Diagram of Management Company Model]

The management company purchases and installs the HBO equipment, employs the staff, and otherwise provides a “turn-key” product to the hospital. The Manager could charge a flat monthly fee for its services, which could be the safest way to calculate the fee and avoid any scrutiny under

26 42 C.F.R. § 410.33(b)
27 Medicare Hospital Manual, § 207.
the Stark or Anti-Kickback statutes. However, a flat fee doesn’t take into account fluctuations in 
patient census and could result (in fact by definition would result) in the fee being above or below 
fair market value in any given month. Moreover, as a business matter, the hospital is obligated to 
pay a monthly payment, even if no business is generated. The Manager has its costs covered, and 
has little incentive to build HBO business.

In interpreting the “volume or value” standard, the Stark I Phase II final rule authorized the 
use of “per use” or fee for service arrangements where physicians or physician entities provide 
services to DHS entities such as a hospital. The HBO management company thus could propose a 
fee schedule to the hospital for the specific services provided under the agreement. Those services 
would correspond, per CPT code, to the same services the hospital would bill to the appropriate 
payor. If the Medicare payment amount for a particular procedure was $250, the Manager’s fee 
might be $165. Thus, completely consistent with the Stark statute, the physician-owned entity could 
receive additional compensation for each referral for HBO services made by one of the referring 
investors.

Even though that result is acceptable under the Stark statute, counsel still must analyze the 
arrangement under the Anti-Kickback statute. The safe harbor for personal services arrangements 
under the Anti-Kickback statute provides, among other things, that the compensation provided to the 
party providing the personal services cannot be related to the volume or value of referrals or business 
generated between the parties. It does not define volume or value as CMS has done under the Stark 
statute. Counsel must analyze the entire transaction and make a judgment whether the fee-for-

service nature of the contract raises substantial risk under the Anti-Kickback statute. Ultimately, that 
is a balancing test, and a risk to be assessed by the parties. The argument in favor of the fee is that in 
order to be able to calculate the fee as close to fair market value as possible, it must bear some 
overall relation to the amount of resources expended by the Manager. If a flat monthly fee is used, 
in months where there are few referrals, the hospital will be overpaying for the service; and indeed, 
such overpayment might be considered to be an inducement for the referral of future business. By 
the same token, in those months that are extremely busy, where the Manager is “overworked and 
underpaid”, the conclusion could be that the physicians are willing to pay such remuneration to the 
hospital in exchange for the continued opportunity to manage the HBO department. The parties are 
cought between a rock and a hard place, and these type of services almost demand a fee-for-service 
fee, even though such formula falls outside of the applicable safe harbor.

IV. Tax Exempt Entity Considerations

A. Overview

If a tax exempt entity will be participating in a for profit joint venture, counsel for the tax 
exempt entity must consider the possible impact of the venture on the entity’s exempt status. Similarly, counsel for the other joint venture partners must be wary of the possibility of imposition 
of IRS intermediate sanctions on insiders (“disqualified persons”) who receive excess benefits 
through the transaction with the exempt entity. All parties thus have an interest in structuring the 
transaction to avoid IRS scrutiny.

Tax exempt considerations primarily come up in the context of true joint ventures, like 
jointly owned hospitals, ambulatory surgery centers, or imaging centers. Pseudo ventures like
equipment leases and management agreements tend to pose less of a threat to the exempt status of the organization.

Historically, the IRS had an absolute prohibition against exempt organizations serving as general partners in partnerships with private investors. That per se prohibition was lifted in 1980 with the Plumstead decision.\footnote{Plumstead Theater Soc’y., Inc. v Commissioner, 74 T.C. 1324 (1980), aff’d. 675 F. 2d 244 (9th Cir. 1982).} In Plumstead, a theater company, created to promote the performing arts, entered into a limited partnership with private investors to fund and promote a stage play. The IRS denied tax-exempt status to Plumstead, concluding that because of the presence of and profit motive of the private investors, it was not operated exclusively for charitable purposes. The tax court reversed, and articulated a two prong test to determine whether a transaction involving a taxable “partner” might jeopardize an exempt organization’s status. First, does the transaction further the exempt organization’s charitable purpose, or is it just a sham transaction to distribute profits and revenues to non-exempt persons? Second, does the organization retain sufficient control over the joint venture, in order to be able to assure compliance with its exempt mission? If the exempt organization can prove compliance with those tests, the venture is presumptively valid.

B. Revenue Ruling 98-15

Although the IRS did not agree with the Plumstead decision, it eventually embraced the holding. Years later, the IRS attempted to further refine and apply the Plumstead test to hospital joint ventures in Revenue Ruling 98-15. In that ruling, the IRS looked at two “whole hospital” joint ventures, concluding that the exempt entity in hypothetical Situation 1 properly protected and preserved its exempt status, while the organization in Situation 2 improperly ceded control over the venture to its for profit partner. In each example, a tax exempt hospital contributed all its assets to a new limited liability company, with one or more for profit hospital partners. The new organization then executed a management contract with a third party management company. While outwardly similar, the transactions had different governance and control attributes, and the IRS focused on those aspects in defining “good” and “bad” joint ventures.

Key aspects the IRS found objectionable in Situation 2 were as follows:

- The governing board was not controlled by the exempt organization, but was merely a 50/50 board;
- The governing documents failed to require the parties to operate the venture consistent with the hospital’s exempt status;
- the hospital management contract was a long-term contract, and was entered into with a subsidiary of the taxable partner, rather than an independent third party;
- key officers of the entity were former employees of the taxable partner;
the governing instruments of the LLC required “minimum” distributions to the members, even without consent of the exempt member.

Conversely, each of those “bad” factors turned in favor of the exempt entity in Situation 1. In Situation 1, the tax exempt member appointed three members of the LLC’s governing board, and the taxable member appointed two. In addition to control of the governing board, the LLC operating agreement required that the LLC operate any hospitals it owned in a manner that fostered charitable purposes by promoting health for a broad cross section of the community. It also required the LLC’s governing board to promote charitable purposes in a way that overrode their duty to operate the LLC for the financial benefit of its owners.

While 98-15 was useful in outlining “good” and “bad” joint ventures, it did little for the middle of the road type transaction that might have one or more attributes from each of the hypothetical examples in 98-15. The two examples were so diametrically opposed to one another that the industry is still left to contemplate just which factors might, if modified slightly, protect the transaction for the exempt organization.

Because 98-15 specifically applies to whole hospital joint ventures, where the exempt organization contributes everything to the venture, and essentially has no assets remaining, the effect of 98-15 on more limited ancillary joint ventures, such as imaging centers and surgery centers, has not been entirely clear. The IRS has not specifically applied 98-15 to ancillary joint ventures between taxable and tax exempt parties. However, the overall lesson to be learned from 98-15 can easily be applied to ancillary ventures: namely, that exempt organizations entering into arrangements with taxable entities must ensure they have not relinquished control over the entity, or have hampered their ability to ensure the organization is operated to further charitable purposes.

C. Redlands

A few years later, the U.S. Tax Court expanded the concepts in 98-15 to ancillary joint ventures. The Redland’s case involvement of a not-for-profit subsidiary of an exempt hospital system parent that formed a joint venture surgical center with a for profit entity and other private investors. The sole activity of the exempt subsidiary was the surgery venture. The Tax Court applied the reasoning of Revenue Ruling 98-15, (without referencing it by name) and after evaluating many factors, concluded that the hospital subsidiary improperly ceded control over the venture to the for profit partner. The hospital subsidiary lacked not only voting control of the management board (having only a 50/50 Board), but also lacked any formal or informal operational control sufficient to assure that the entity would be operated for charitable purposes. The court held for example that the mere power to veto actions was insufficient to demonstrate true control.

As in Situation 2 of Revenue Ruling 98-15, the Redland Joint Venture documents lacked any express or implied obligation of the parties involved to put charitable objectives ahead of non-charitable objectives. Also similar to 98-15, the venture ceded management control over the day-to-day operations of the venture to the for profit partner and created a compensation structure that maximized the incentives for profit in the joint venture. Overall, the for profit partner seemed to

---

29 Redlands Surgical Services, Inc. v. Commissioner, 113 T.C. 47 (1999), aff’d 242 F. 3d 904 (9th Cir. 2001).
benefit to a greater degree than Redlands and the tax court ruled that the venture was not operated exclusively for charitable purposes within the meaning of Section 501(c)(3) of the Internal Revenue Code. Essentially, the Redland’s case involved a worst case fact situation, and the tax court decision was affirmed without opinion by the Ninth Circuit.

D. St. David’s

A year later, the tide finally turned in favor of the exempt organization with the St. David’s Healthcare System case. St. David’s, a non-profit hospital in Austin, entered into a limited partnership with HCA, a for profit hospital company. St. David’s contributed all of its hospital assets and HCA contributed all of its Austin area hospital assets to the new partnership. St. David’s received 46% of the partnership while HCA retained 54%. The IRS revoked St. David’s tax exempt status retroactive to the partnership’s formation in 1996 on the grounds that St. David’s participation in the partnership did not allow it to act exclusively in furtherance of its charitable purposes.

The District Court overturned the IRS determination, dismissing the IRS’s claims that St. David’s was not controlled by a community board. Although the Board membership was 50/50, St. David’s could demonstrate it retained real control over the Board and the mission of the organization. Those protections on behalf of St. David’s included (1) a requirement that all of the hospitals owned by the partnership be operated in accordance with the community benefit charitable standard, (2) St. David’s had a unilateral right to dissolve the partnership in the event the hospitals failed to meet that standard, (3) the Chairman of the Board must be a St. David’s Board member, and finally, (4) St. David’s had the right to unilaterally remove the CEO of the partnership. In reversing the IRS decision, the District Court concluded that it was “difficult to imagine a corporate structure more protective of an organization’s charitable purpose than the one at issue in this case.”

Exempt Organization Joint Venture Checklist

The following checklist will help the parties assess the degree of risk to the exempt organization of the joint venture. IRS exempt-organization specialists use a similar checklist in auditing joint ventures.

- Did all entities receive an ownership interest in the venture proportionate to the value of the assets contributed? Was there a valuation for contributed assets?
- Who will own the majority of the venture? Will the tax exempt entity have sufficient control of the venture to assure itself that the venture serves community benefits?
- What percent of board representation will the tax-exempt entity have? Does the tax exempt entity have voting control of the board? If so, how much control will be provided to the board? If the tax-exempt entity does not control the board, what reserve powers will the entity have?

have? Will physician committees have such power so as to undermine board control?

- Does the joint venture agreement explicitly state that the joint venture’s duty to further charitable purposes overrides its duty to operate for the financial benefit of its partners/members?

- Will the venture be accessible to Medicare and Medicaid patients? Will the venture have a charity care policy?

- Will the venture have an open medical staff or be limited to physician investors?

- Will the tax-exempt party be the only party serving as a loan or lease guarantor?

- Does a company related to the for profit partner/member manage the day-to-day operations of the venture? If so, are the terms of the management agreement comparable to industry standards? Does the tax exempt entity have the unilateral right to terminate the management agreement if the management company is not acting in furtherance of the exempt organization’s charitable purposes?

The lessons today for non-profit entities are essentially the same as articulated by the tax court in its 1980 Plumstead decision. A tax exempt entity may participate in a for profit joint venture with a taxable entity so long as (1) the participation furthers the tax exempt entity’s charitable purposes, and is not merely a sham to share revenues and profit with insiders, and (2) the tax exempt organization must retain sufficient control of the activities of the venture to ensure its charitable purposes are met, and ensure that the arrangement does not result in more than incidental private benefit to the non-exempt partners.

E. Intermediate Sanctions

Hospital counsel is not the only one who must be sensitive to tax exempt issues arising in a for profit joint venture. The exempt entity faces issues related to potential revocation of its exempt status, as discussed above. However, that organization and all participants in the joint venture (whether for profit entities or individuals) must carefully consider any transaction that involves the tax-exempt entity and from which they personally benefit in some manner. If such a transaction is deemed to be an “excess benefit transaction” subject to intermediate sanctions, both the tax-exempt entity and joint venture participants may be subject to substantial monetary penalties.

The IRS published final intermediate sanctions regulations in January 2002, pursuant to authority granted by Congress. The essential concept behind these regulations is that a sanction, rather than revocation of charitable status, is now available to the IRS in order to deal with a “disqualified person” or “organization manager” who participates in an “excess benefit transaction” with an “applicable tax-exempt organization.” Under prior law, the only leverage the IRS had was

---

revocation of charitable status, which often was an overly punitive remedy for the problems encountered.

A “disqualified person” is any person who, within 5 years prior to the questioned transaction, was in a position to exercise substantial influence over the affairs of the organization, as well as that person’s family members and any entity in which that person and his family hold more than 35% of the voting power (for a corporation), profits interest (for a partnership) or beneficial interest (for a trust).

Always included as a “disqualified person” is any voting board member, the CEO, COO and CFO (if any), and the treasurer of the organization. An officer in his or her first year may thus be a disqualified person with respect to his or her initial contract with the organization, but payments under that contract that are expressed as fixed amounts or determined under an objective formula should not be subject to these rules.

Not included as a “disqualified person” is (A) any 501(c)(3) entity; (B) any 501(c)(4) entity that is subject to these regulations (not all are); and (C) any person who (i) works for the organization either full- or part-time; (ii) is not described in the preceding paragraph; (iii) is not a substantial contributor to the organization; and (iv) makes (from all sources of income received through the organization) less than the amount deemed in Code section 414 to make him or her a highly-compensated employee (for 2002, that amount was $90,000.00).

Everyone else’s status as a disqualified person will be determined based on the facts and circumstances of that person’s situation. Factors that tend to support or refute an individual’s status as a disqualified person are set forth in the regulations.

An “excess benefit transaction” is any transaction in which an economic benefit is provided directly or indirectly to a disqualified person by the organization, if the value of the consideration provided to the disqualified person exceeds what the organization receives in return. Covered transactions may, for example, include payment of compensation for services rendered, business and investment transactions, and sales or purchases off assets.

Penalties under the intermediate sanction regulations are severe. First-tier taxes are 25% on the disqualified person, as well as a 10% tax on any organization manager who knowingly participated in the transaction. Failure to correct the tainted transaction can result in an additional penalty of 200% on the disqualified person. In the first case brought by the IRS pursuant to the final regulations, the U.S. Tax Court upheld the imposition of severe penalty excise taxes stemming from the transfer of charitable assets by an exempt home health agency to members of the family that owned the agency. The court approved $11.6 million in penalties, and required the return of the improperly transferred assets.32

Intermediate sanctions are here to stay, and counsel for the exempt organization as well as the for profit entity, as well as the managers of the exempt organization, should pay particular attention to any transactions with individuals who may potentially be viewed as “disqualified persons” under the law.

32 Caracci v. Commissioner, 118 T.C. No. 25 (May 22, 2002).
IV. Conclusions

If you’ve seen one deal………you’ve seen one deal. One size clearly does not fit all, and retaining counsel up front to accurately evaluate the risks and rewards of a proposed joint venture can save the parties enormous amounts of time and money. Assessing the reimbursement issues associated with the venture, while concurrently analyzing the Stark and anti-kickback risks inherent in the model desired by the parties, is a vital role played by healthcare counsel. Tax exempt organizations have their own unique requirements as well, and all the parties to a venture with such an organization must comply with IRS guidelines for exempt organizations.

When necessary, creatively altering the parties’ proposed structure, while recognizing and maintaining their clinical and business expectations, gives counsel the opportunity to add real value to the transaction.
JOINT VENTURE HYPOTHETICALS
Hypothetical I—Smallville Imaging

Acme Oncology is a 6 doctor medical group in Smallville. Acme has decided it is tired of sending all of its MRI's and CT's to Smallville Community Hospital (SCH), and wants to invest in its own imaging equipment, by building a free-standing imaging center 4 blocks from SCH. Since none of the Acme doctors are very good at reading MRI's, they decide to contract with Smallville Radiology, the largest radiology group in the county.

Smallville Radiology says they would be willing to work with Acme, but only if they can have an ownership interest in the imaging center. Acme's lawyer, Bob Barrister, is the president of the local bar, and has handled all of Acme's business and real estate matters for years, and he thinks the Imaging Center is a good idea. He has even heard about the Stark statute, and he was told that radiologists are not covered by that law. Bob thus suggests that Acme and Smallville Radiology form a limited liability company called Smallville Imaging. Smallville Imaging will own the equipment and the building, will bill all patients and payors, and the groups will divide the Imaging Center profits 50/50. Because Acme will provide most of the patients, (and because after all it was their idea) Bob Barrister wisely negotiates that Acme will put up only 45% of the investment, but keep 50% of the profits. Smallville Radiology reluctantly agrees.

Immediately prior to closing the deal, Acme contacts you as a health law expert, and asks you to bless the transaction. What will be your advice to Acme?

1. What laws must be examined as the parties evaluate the proposed transaction?
2. What specific aspects of the deal should be addressed?
3. Can Acme refer patients to Smallville Imaging? If not, why not?
4. Would another structure work better?
5. Can Acme keep 50% of the profits?
Hypothetical II—Smallville ASC

When the administrator for not for profit Smallville Community Hospital hears about Acme and Smallville's plans, he is not happy. SCH's administrator convinces his community-based Board of Directors that for SCH to stay competitive, it needs to develop closer relationships with area physicians. Building a competing imaging center of course would be wasteful and duplicative. However, the administrator is convinced the easiest way to build relationships is to build an ambulatory surgical center (ASC), and offer ownership interests in the ASC to a local orthopedic group, Western Orthopedics, as well as several other independent surgeons. SCH proposes to form a limited liability company (LLC) owned 50% by SCH and 50% by Western and other surgeon investors. SCH commits that it will borrow all the necessary money for the equipment, and guarantee the loan, so that the doctors won't have to worry about the finances, but can focus on treating patients.

SCH hires a well-known healthcare consultant, Strategic Consulting and Brokering, to put the deal together. SCAB advises the parties that the Stark statute will cause them problems, and thus recommends that only non-Medicare/Medicaid patients be treated at the ASC, and all Medicare/Medicaid patients instead be treated at SCH itself. The parties agree to send all Medicare/Medicaid patients requiring surgery to the hospital.

Western Orthopedics is represented by Rachel Barrister, Bob's sister-in-law, and she also is an excellent negotiator. She shrewdly requires that Western receive an additional 5% ownership after six months, out of SCH’s share, if ASC business exceeds projected levels. She also insists that at that point the physician investors collectively would have a majority of the managers of the LLC.

Finally, since the Medicare and Medicaid patients will be referred to the hospital, the parties agree that payment up front should be required for all services at the ASC. Patients without insurance or private resources should be treated at the hospital, because, after all, that is its mission. The ASC needs to be successful.

You have been retained by SCH to advise it on the proposed transaction. The administrator is looking for creative advice, not simply a regurgitation of the law. What will you tell him?

1. Is sending all Medicare/Medicaid patients to the hospital necessary to protect the parties against a Stark violation?
2. Is sending all the Medicare/Medicaid patients to SCH a good idea?
3. Can Western receive an additional 5% if the first six months is a success? What about after one year?
4. Is it acceptable for SCH to have less than 50% of the managers of the LLC, once its interest goes below 50%?
5. As long as SCH’s Board votes to approve the transaction, are all the negotiated points described above acceptable for SCH?
Hypothetical III—Smallville Radiation Therapy

Acme Oncology is excited about the success of its imaging center joint venture. Its main competitor in town, Small Tumor, decides that it too would like to expand its practice into ancillary services. The imaging center and ASC ideas have already been taken, so Small Tumor retains you to help it structure some sort of ancillary services joint venture. Radiation therapy services looks like a possible candidate.

Currently, when a Small Tumor (“Small”) patient requires radiation therapy treatments, the Small radiation oncologist treats the patient on an outpatient basis at SCH, which historically has had an adequate clinical oncology program. Small believes that new and better equipment is available, however, and also believes a free-standing outpatient center would be well received by the community. Small thus tells you it would like to form a venture with SCH to purchase and operate a new EX Linear Accelerator. Small would send its patients to the Center for radiation therapy treatments. The Center would be a new entity that would bill all payors under its own name. The president of Small has already had preliminary discussions with SCH, and SCH likes the idea.

Fortunately Small consulted you on the front end. You advise them that radiation therapy services are designated health services under Stark, and if they intend to treat Medicare or Medicaid patients, the joint venture structure just won’t work. Either Small Tumor must bill for radiation therapy technical services through its own practice, or SCH or an SCH owned entity must bill for the services. Small tells you it really wants to work some arrangement with SCH, and desperately wants new equipment. Can you suggest a structure that will work?

1. Is it true that billing through a jointly owned entity will not work?

2. Is there an alternative structure that you can suggest to your client, that will meet some of their business and clinical goals, but will not run afoul of the Stark or anti-kickback statutes?