

Physician Joint Ventures: New Opportunities and Risks

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Joint ventures involving physicians and institutions or lay investors had fallen out of favor in recent years because of concerns about transgressing government regulations. These regulations have now been clarified leading to a resurgent interest in these arrangements. This article outlines the business principles, control issues, legal setting, and the various modalities for joint venturing.

Key words: Joint ventures; physician-hospital joint ventures; safe harbor laws; anti-kickback regulations.

Physician participation in health-care joint ventures—quite common in the 1980s—was virtually regulated out of existence in the 1990s. Joint-venture activity is now back with a vengeance. The renewed interest has been fueled by factors such as

- declining physician income;
- competition for referrals;
- the desire for access to the latest technology; and
- surprisingly, some new regulatory flexibility.

The most commonly joint-ventured businesses are surgery centers (including endoscopy suites), imaging facilities, clinical laboratories, specialty hospitals (such as heart hospitals), chronic dialysis centers, and lithotripters. Physicians are joint venturing with other physicians, hospitals, nonprovider entrepreneurs, and combinations of all of the above.

This article guides readers through the complex web of issues common to most joint ventures and highlights special considerations for surgery centers, imaging facilities, and labs.

COMMON JOINT-VENTURE ISSUES

Regardless of what is being joint ventured, a number of important issues have to be considered:

- **Financial feasibility.** Is there a business plan for the joint venture and does it make sense? How do the financial feasibility projections look? Have they been prepared by a competent, unbiased party? Are the projec-

tions conservative or aggressive? What are the financial risks to the participants if the joint venture fails?

- **Legal feasibility.** A financially feasible joint venture must also be legally feasible. If physician investors will be making referrals, the joint venture must be carefully structured to ensure compliance with the federal Stark law (42 U.S.C. Section 1395nn) and the Medicare-Medicaid Anti-Fraud and Abuse Statute (42 U.S.C. Section 1320a-7b).
 - Most states also have anti-kickback laws, and many have their own “mini-Stark” laws, which apply even if no Medicare patients are involved. If Stark applies, then qualifying for an exception is mandatory; qualifying for a “safe harbor” to the Fraud and Abuse Statute is certainly desirable but not required.
 - Other legal feasibility issues include Medicare coverage requirements for payment; certificate-of-need review; state licensure; and Medicare or private certification or accreditation. If one of the joint-venture participants is a tax-exempt organization, such as a hospital, there are additional legal requirements to protect the organization’s tax-exempt status and ensure that the joint venture does not violate the Internal Revenue Service’s “inurement” and “private benefit” rules.
- **Financing.** Will the joint venture be financed solely through the capital contributions of the owners or supplemented with loans? Will the venture participants be required to make additional capital contributions if the venture starts running out of money? Will any loans require personal guarantees? Can up-front costs be reduced through the leasing of facilities and equipment? If physicians are offered preferred financing terms,

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fraud and abuse and other legal compliance issues may be raised.

If physicians are offered preferred financing terms, fraud and abuse and other legal compliance issues may be raised.

- **Choice of entity.** What form of legal entity will be most suitable for the joint venture? Typically the choices include a general business corporation, a professional corporation, a limited liability company or partnership, a limited partnership, or some combination of the above. Ultimately, the entity choice will depend upon where the joint venture will operate and liability, control, tax, and other considerations.
- **Sharing of profits.** How will profits (and possible losses) be shared among the joint venture's owners? Generally, to be compliant, profits have to be distributed based upon ownership percentage and not in accordance with referrals. Profit percentages do not necessarily have to be the same as voting percentages. Physicians should also be aware of potential profit "skimming" through above-fair-market-value management agreements and leases.

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- **Management and control.** Control issues can be difficult to resolve. Hospital and nonphysician businesses often believe they have a right to control the joint venture. This is not true in my view. Further, while control often follows ownership percentage, it does not have to. At one extreme, a hospital could be the controlling general partner of a limited partnership where physicians own half of the equity interests. On the other hand, physicians could own a minority of the membership units in a limited liability company but share equal control with the hospital as a co-manager. Tax-exempt hospitals will have limitations on how much control they can share with other venture participants. Even if one participant has more than 50 percent of the voting power, the joint venture documents can provide that certain key decisions will require a super-majority (two-thirds) vote for approval. Careful consideration should also be given to the difference between the ultimate control of owners and day-to-day control, which can be vested in a chief executive officer or in one of the venture participants through a management services agreement.
- **Buy-Sell provisions.** The all-important buy-sell provi-

sions determine when a venture participant's ownership interest can be bought out and at what price. Typical buy-out trigger events for physicians include retirement, relocation, disability, or loss of medical license. Serious fraud and abuse issues are raised if a buy-out can be triggered by decreased referrals to the joint venture. The buy-out purchase price can be fixed in advance or determined by a formula or appraisal. Buy-out payments can be made all in cash or partly in cash with the balance paid in installments over a number of months or years. Caps on total, annual buy-out payments should be considered in the event of multiple departures.

- **Restrictive covenants.** Restrictive covenants can apply both while the person is participating in the joint venture and after a buy-out. Restrictions can be placed on investing in or providing services to a competing business; soliciting patients, customers, referral sources, or joint-venture personnel; and disclosing trade secrets and other confidential information. Except in certain managed settings, the joint venture cannot restrict physician owners from making referrals to competing providers. Physicians should be wary of restrictive covenants that apply to them but not to other investors.

Other important issues include:

- Compliance with federal and state securities laws
- Providing for the restructuring or unwinding of the joint venture if there are changes in compliance requirements
- Dispute resolution mechanisms (such as mediation, arbitration, and court)
- Labor and employment law considerations, including retirement plan issues

SPECIAL ISSUES FOR SPECIFIC JOINT VENTURES

Surgery center, imaging facility, and clinical lab ventures raise special issues.

Surgery Centers

Ambulatory surgery centers continue to be among the most common joint ventures. Advances in technology enable more procedures to be performed outside of the hospital setting. Physicians want a share of the facility fee, and hospitals and surgery center entrepreneurs realize they need physician partners to have a reliable source of referrals. The financial feasibility of a surgery center depends upon a number of factors, including the case and payer mix, volume, and development costs.

Surgery center joint venture structures include:

- Owning and operating the surgery center
- Operating a surgery center facility that is leased from a third party
- Owning the surgery center facility but leasing it to a third party who operates it

- Time-sharing the surgery center with separate practices or parties

Medicare will certify two independent operators of the same surgery center as long as each operator has the exclusive use and control of the facility during its time slot—e.g., on alternate days of the week. Some states' laws (such as California) may not permit shared surgery centers, however.

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Surgery center joint ventures also present unique compliance issues including the Medicare Fraud and Abuse Statute. Physicians risk possible prosecution if the federal government believes that even one purpose of profit distributions to the owners is to pay for or induce patient referrals. Fortunately, the Office of the Inspector General (OIG) has established safe harbors for surgery center joint ventures and issued a number of advisory opinions approving of surgery center joint ventures that do not meet the strict safe-harbor requirements:

- There is a safe harbor for surgery centers owned only by physicians who practice in the same medical specialty and derive at least one-third of their medical practice income from the performance of ambulatory surgical procedures.
- There is a second safe harbor for physician-owned surgery centers where the physicians practice in different specialties and both derive one-third of their income from ambulatory surgery procedures and perform at least one-third of such procedures in the surgery center in which they are investors.
- And there is a safe harbor for surgery centers that are co-owned by physicians and a hospital. Among other things, the hospital may not be in a position to make or influence referrals to any physician investor or to the surgery center joint venture.

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The surgery center safe harbors clearly are not intended to permit participation by physician investors who do not perform ambulatory surgical procedures but would be a source of referrals to the surgery center. Such physicians might qualify for the small-entity safe harbor that requires, among other things, that those in a position to make or influence referrals own not more than 40 percent of the value of the ownership interests in a surgery center, *and* that not more than 40 percent of the surgery center's gross revenues come from referrals from investors.

Further, the OIG acknowledges that even if a surgery center investment does not qualify for a safe harbor, it is "not necessarily unlawful, provided that payments made in return for the investment are not for the purpose of inducing or rewarding referrals."

In general, the "Stark" law does not apply to physician services performed in a surgery center.

In general, the "Stark" law does not apply to physician services performed in a surgery center. If "designated health services," such as lab and implanted prosthetics and prosthetic devices, are provided, however, then Stark could apply. Fortunately, Stark provides exceptions for these items as long as certain requirements are met. For example, lab services do not present a Stark problem if payment for the lab services is included in the ambulatory surgery center rate and are not billed separately.

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Various state laws may also have to be considered, including those related to self-referrals, certificate of need, and licensure of the surgery center.

Imaging Facilities

Imaging facility joint ventures include multi-modality centers, as well as those specializing in MR, CT, and/or PET. New technology, competition for referrals, access to capital, and physicians' wanting to share in the technical fee are all driving imaging facility joint venture activity. Venture participants include referring physicians, radiologists, hospitals, and entrepreneurs. Financial feasibility is determined by factors such as the modalities to be offered (CT, MR, and nuclear are generally better paid than plain film x-ray, mammography, and ultrasound), payer mix, volume, and development costs.

Imaging facility joint ventures can take many forms, including the following:

- Traditional joint ventures with independent physicians, medical groups, an imaging company, and/or hospital investing in an entity that provides and bills for imaging services, usually as an independent diagnostic testing facility (IDTF).
- Nonprovider joint ventures where the investment entity acquires the imaging equipment and other technical components. The joint venture does not bill for its services; rather, it acts as a vendor selling the technical com-

ponent of the test to a medical group that is one of the owners of the joint venture. The group performs the tests on its premises and bills for them as in-office services.

- Shared facilities where practices do not have sufficient patient volume to justify full-time use. A number of medical groups form an entity that acquires the imaging equipment and, on an as-needed basis, provides various aspects of the technical component to each member group. Groups, in turn, pay the entity for their share of the expenses of the jointly owned entity based upon their usage. Each medical group bills for tests performed for its patients. Revenue is not pooled or shared.
- Block purchasing of scanner time where independent medical groups purchase pre-designated blocks of time to use equipment owned by an imaging company, whether from a mobile service or a fixed site. The medical group pays a flat fee to use the scanner, for example, one day per week. Commitments usually extend at least one year. The medical group risks its money if it does not have sufficient patients to test and bill during its designated time.

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Each of these models presents a variety of compliance issues under federal and state law. For example, under the Medicare Fraud and Abuse Statute, making an investment in a traditional imaging joint venture can be problematic unless it can qualify for the small-entity safe harbor previously described or the physician investors are limited to radiologists who generally are not considered to be making referrals.

The Stark law also poses problems for such joint ventures except for nuclear medicine, which is not covered by Stark. Even with other joint-venture models intended to qualify for Stark's in-office ancillary service exception, the requirements for physician supervision, the location of the imaging facility, and billing for its services will have to be met. Adequate physician supervision will also be required for Medicare coverage and payment.

Other Medicare Rules

Several other Medicare rules may also come into play. The Purchased Diagnostic Test Rule (PDTR, Claims Processing Manual, Transmittal 135) provides that if a physician bills for diagnostic tests performed by an outside supplier, the physician cannot be paid by Medicare for more than what the supplier charged. To avoid the anti-markup provisions of the PDTR, at a minimum, the physi-

cian must personally perform the test or supervise it or have it supervised by a physician with whom he or she shares the practice. The Medicare "reassignment" rule prohibits a physician who furnishes a service from assigning to someone else his or her right to receive payment unless an exception applies. For example, if a medical group participant in an imaging joint venture contracts with an independent radiology group to interpret scans, the medical group may not be able to bill globally to include the radiologist's interpretation unless (a) the tests are initiated by a physician or medical group independent of the person or entity providing the test, and of the medical group providing the interpretations, or (b) there is a formal reassignment to the medical group.

Lab joint ventures raise many of the same compliance issues as imaging facility joint ventures.

Imaging joint ventures can also raise state law compliance issues including state self-referral and anti-kick-back laws, certificate-of-need review, state licensure, and physician supervision.

Lab Joint Ventures

Smaller physician practices are sometimes interested in joint venturing a lab where the physicians are in an expense-sharing arrangement in the same office suite or located in the same medical office building. Lab joint ventures raise many of the same compliance issues as imaging facility joint ventures. The Medicare Fraud and Abuse Statute and Stark apply, and there are often comparable state laws to consider. A shared lab should be able to qualify for the Stark law's in-office ancillary services exception as long as the lab and all of the physicians are located in the same suite or building. Each medical group or physician must also supervise the tests for its patients. A shared arrangement should not violate the Medicare Fraud and Abuse Statute because the shared entity allows each medical group to provide tests to its patients rather than making referrals to a jointly owned entity and receiving a profit distribution.

CONCLUSION

With downward pressure on physician incomes expected to continue, the interest in revenue-supplementing joint ventures will likely increase. At the same time, the factors necessary to make the joint venture financially feasible may be at odds with legal compliance requirements. Further, federal and state regulators are increasingly concerned that joint ventures may lead to overutilization of services. Therefore, each joint venture must be very carefully analyzed and structured. ■