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The Bill Chill: Safe Harbors in the Medicare and Medicaid Fraud and Abuse Statutes

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THE BIG CHILL: SAFE HARBORS IN THE MEDICARE AND MEDICAID FRAUD AND ABUSE STATUTES

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I. INTRODUCTION

Living the American dream, held so dear by so many for so long, has always included receiving the best medical care money can buy. In the case of Medicare patients, it is government money that is being spent to give older Americans quality health care at an age when they often need it the most. There is a direct correlation between aging and increased utilization of health services.1 In a country where the "younger" old are using medical resources which originally were thought to be reserved for the "older" old,2 what will happen by the time the so-called "baby boomers" reach the golden age of retirement? Faced with Medicare expenditures increasing at an alarming rate, the government was determined to do something about it.3 It obviously could not stop patients from seeking medical care, and equally obviously it could not require all the private physicians practicing medicine throughout the United States to reduce medical expenses. Instead, it determined to restrain hospitals and hold them accountable for the rising cost of health care.

While certainly a contributor to the problem of rising health care costs, the hospital industry cannot be blamed solely for the medical malaise

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2 The term "younger" old has found its way into the literature to describe individuals in their early retirement years, generally ages 65 up to 80. The "older" old are generally defined as individuals over 80. As life expectancy has increased, individuals in their 60's many times find themselves caring for a parent in their 80's.
which grips America today. Health care costs account for one of every eight dollars of the Gross National Product (GNP). This is double that of Japan and fifty percent higher than other developed countries. Despite this, Americans still cannot get many services they need or want. Business and government combined pay for more than 80 percent of health care bills. So it has fallen to big business and the government to put the brakes on the runaway train. Despite all efforts, "costs proved intractable and services remained inconvenient and variable in quality." What went wrong? Why is it that although we have vastly improved our ability to diagnose, monitor, cure and account for the cost of each and every disease, the ills of the industry persist? These ills persist despite an aging population which has created a "whole sub industry of geriatric care" and despite the fact that women, who are the prime consumers of health care, have joined the work force in burgeoning numbers, thus raising family incomes. Why has the Federal government failed to solve a problem which it has literally been throwing money and human resources at for years?

One effort on the part of government and some political leaders to curtail health care costs over the last decade has been the introduction of the Medicare and Medicaid Fraud and Abuse statutes and their counterpart, the safe harbor regulations. Although yet to be enacted in final form, the proposed safe harbor regulations, and some recent case law, have given those involved in health care delivery systems reason to pause, reassess and ponder what lies ahead.

This Note will determine whether the safe harbor regulations, intended to advise hospitals of permissible conduct, have instead created a chilling effect on the competitive market place. Have governmental regulations, in the form of safe harbors, failed to produce clear answers and guidance to hospitals? It would appear that instead of clarifying the issues, these new proposed safe harbor regulations have, in fact, prevented hospitals from offering patients and the federal government cost savings in the form of discounts and rebates.

II. BACKGROUND

Prior to the 1983 Medicare Prospective Payment System, Congress had revised the fraud and abuse provisions of the Social Security Act. This

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5 Id.
6 See id. at 96.
7 Id.
8 Id.
10 Pub. L. No. 92-603, § 242(b), 86 Stat. 1329, 1419 (1972). These provisions prohibited the solicitation, offering, paying, or accepting of kickbacks or bribes in connection with the provision of services or items under the Medicare/Medicaid Program.
revision occurred in 1972 and it was again revised in 1977. The end result was that Congress authorized the imposition of criminal sanctions for "knowingly and willfully" defrauding the Medicare or Medicaid programs. The statute states: "Whoever knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under this subchapter . . ." is guilty of fraud. These criminal sanctions included a maximum fine of $25,000 and/or imprisonment of up to five years. Congress then carved out an exception to these amendments which excluded discounts or price reductions which are disclosed and passed on to the patient and third party payor.

The original purpose of this fraud and abuse legislation was to curtail the activities of "Medicaid mills," storefront purveyors of substandard health services, who shared their gross profits, via a percentage lease, with their landlords. Congress also sought to catch freestanding labs, nursing homes and independent practitioners participating in kickback schemes in this net. Fraud was defined as "intentional misrepresentation." Implicit in the definition describing misuse and abuse was the notion that no fraud existed if a provider used "sound medical practices," as defined by existing medical community standards.

Legislative history further indicates Congressional intent was such that if an action did not cost the Medicare program an excessive amount of money, it should not fall under the fraud and abuse section of the law. In the legislative history, providers were encouraged to seek discounts to save the Medicare program money.

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11 Medicare & Medicaid Antifraud and Abuse Amendments. Pub. L. No. 95-142, 91 Stat. 1179 (1977) (codified at 42 U.S.C. § 1395 (1982)). These amendments broadened prohibited conduct to include the offer, payment, solicitation, or receipt of any remuneration in order to induce business reimbursed under the Medicare/Medicaid Programs.


14 Kadzielski, Joint Ventures: Beyond the Safe Harbors, HEALTH PROGRESS, May 1989, at 70. The Medicare and Medicaid Patient and Program Protection Act (Public Law 100-93) required the Department of Health and Human Services to prepare regulations which enumerated practices which would not be viewed as criminal offenses under the Social Security Act.

15 See AM. HOSP. ASSOC., SELECT LEGAL ADVISORY COMM. ON MEDICARE, OFFICE OF LEGAL & REG. AFFAIRS, FEB. 1985, No. 2, at 3 (Feb. 1985) [hereinafter AM. HOSP. ASSOC.].


17 Id.

18 Medicare and Medicaid Patient and Program Protection Act (MMPPPA). Pub. L. No. 100-93, 101 Stat. 680 (1987). The MMPPPA required the Department of Health & Human Services to promulgate regulations specifying those practices which would not be subject to prosecution. That requirement is the genesis of the "safe harbor" regulations.
The Select Legal Advisory Committee on Medicare, which concerns itself with the legislative intent of Congress, outlined several considerations a hospital should review prior to instituting a new hospital activity in a 1985 memorandum:

1. Does the activity comply with accepted medical practices and is it a reasonable and legitimate medical activity?
2. Does the activity increase the cost of Medicare or Medicaid programs by allowing the provider to bill the programs twice for the same treatment?
3. Does payment for the activity depend on a percentage arrangement or on the number of Medicare patients seen?19

An affirmative answer to the first question and a negative answer to the second and third questions reduces the likelihood of a violation of the fraud and abuse statutes. The American Hospital Association's (AHA) Select Legal Advisory Committee on Medicare proceeded to analyze various situations which might fall under the purview of the Antifraud and Abuse Amendments.20 While these are opinions only and not to be construed as specific legal advice, they do begin to outline a framework from which one can chart a course.

Amid these hypotheticals there is the additional caveat that a separate assessment should be made regarding payment antitrust reimbursement and tax issues. The committee notes the Internal Revenue Service's (IRS) historic opposition to 501(c)(3)21 participation in joint ventures or partnerships. However, in the early 1980's the IRS indicated approval of such arrangements unless they benefited hospital staff in a transaction not made at arm's length. Specific examples were cited:

1. Physician received a disproportionate allocation of profits.
2. Hospital made unreasonable loans.
3. Real estate owned by hospital sold or leased at less than fair market value.
4. Hospital not properly compensated for its contribution to the arrangement.22

And, in 1983 and 1984, the IRS issued private letter rulings stating that joint ventures between staff physicians and the hospital had no adverse impact on the hospital's tax-exempt status.23

19 AM. HOSP. ASSOC., supra note 15, at 6-7.
20 Id. at 7-19. The AHA mentioned staff privilege fees, percentage of revenue leases, physician incentive payments, bed reservation premiums, hospital discounts, and captive referrals to name a few.
21 I.R.C. § 501(C)(3) (1986). This subchapter deals with organizations deemed exempt from taxation because of a religious, charitable, scientific or educational purpose.
22 AM. HOSP. ASSOC., supra note 15, at 7-8.
23 Id. at 8.
III. POTENTIAL FOR FRAUD AND ABUSE

The Committee went on to outline situations wherein there might be a potential for fraud and abuse based on the Medicare/Medicaid Amendments. The committee appeared to indicate that these practices, while falling outside of the safe harbors, should be considered legitimate business practices.

1. One situation describes a hospital which charges the doctor a flat fee for the use of the hospital facility, staff, or supplies. This might constitute a payment in return for patient referral, in that the Doctor in question might be denied referrals if he or she had no access to the hospital. However, if the physician were hospital-based, the hospital would not be the source of referrals but rather other physicians would be, thus eliminating the potential for abuse.

2. A hospital Radiology department is an example of a hospital charging a hospital-based physician a percentage of the departmental revenues for an exclusive lease. A potential problem could arise if the payments to the hospital were directly related to the hospital’s referral of patients to that physician. The leasing fee must be reasonable, and sound business practices must be followed to exempt this situation from the fraud and abuse provision.

3. Physicians are sometimes given an incentive to reduce hospital utilization of inpatients. This is generally not considered a violation because it is a reasonable business practice and reduces costs to Medicare. A Medicare fraud and abuse violation could be alleged if it could be shown that more patients were being admitted for shorter time frames. However, this situation is generally considered a positive incentive to reduce utilization, which is a goal of the Medicare Prospective Payment System. Some hospitals go so far as to offer non-financial benefits to physicians who reduce their patients' utilization of in-patient hospitalization.

4. A discount of an office lease could be construed as a pay back for referring a patient to the landlord hospital. As long as there is no specific obligation on the part of the physician to refer his patients to the landlord hospital, it is unlikely that a successful complaint could be brought. If, however, the referral arrangement were more explicit, it is possible that a violation might be charged. An exception is made in rural areas where a guarantee of a percentage of salary is sometimes necessary to secure a physician for small communities.24

5. A hospital sometimes pays a premium to a long-term care facility to reserve beds. While meeting with mixed reviews, this practice seems to be viewed as an innovative use of health care resources and not an abuse of the system. While regulations prevent providers from charging Medicare for reserving these beds, if no attempt is made to bill Medicare, then this situation is viewed as making economic sense; especially if the cost is less than the cost of keeping the patient in a hospital bed.

6. Failure to report and disclose hospital discounts is a clear violation of the provisions. If the hospital joins with another to purchase equipment at less than the per unit price if each facility had purchased the equipment on its own, this reduction must be reflected on the cost reports submitted to Medicare or a violation exists.

7. Rebates for hospital group purchasing organizations are questioned only as to the application and amount of the administrative fee. These are situations where hospitals band together to purchase in bulk at a reduced rate. As long as cost is reflected in Medicare claims reports there is no violation. The potential problem is the administrative fee which could be viewed as an overt payment for goods for which Medicare payment was made. However, the administrative fee, it can be argued, is not to induce referrals and therefore is not a violation. Full disclosure should rectify any perceived abuse.25

8. The waiver of co-insurance and deductibles is considered by some as an inducement to enter the health care system. However, it is not considered fraud because it does not cost the Medicare program additional dollars. On the other hand, it does entice usage because it takes away the end-user's requirement of putting their own money up front. This is a tool to increase utilization. This could be viewed as "knowingly and willfully"26 soliciting Medicare patients to come into the institution even though no cash changes hands.27

9. Spun-off hospital functions such as a Home Health Agency doing discharge planning might result in a potential conflict. One could argue that the Medicare program is being billed twice for the discharge-planning functions: once in

25 Am. Hosp. Assoc., supra note 15, at 15. Hospitals have been encouraged by Congress to seek discounts when the results mean savings for both the Medicare Program and patients.
27 Am. Hosp. Assoc., supra note 15, at 16. The law was so written as to discourage overuse or abuse reasoning that a patient will think carefully before putting themselves into a situation which will cost them substantial monies before their insurance kicks in.
the hospital's DRG payment which includes discharge planning and once for the home health agency's discharge planning because it is reimbursable through the home health agency as well.\textsuperscript{28}

A problem still in need of resolution is a regulation designed to permit a hospital to effect cost reduction or enhance revenue which does not result in greater Medicare payments.

In 1985, the Inspector General of the Department of Health and Human Services attempted to secure guarantees from the Department of Justice that it would not prosecute certain health care marketing practices even though such practices probably fell within the scope of the fraud and abuse statutes.\textsuperscript{29} The argument raised was that the practices did not harm the federal government and, in fact, were cost-effective to both patient and provider.\textsuperscript{30} The Department of Justice refused, claiming that doing so would usurp Congress' express authority to make the laws of the land.\textsuperscript{31} If Congress deems conduct criminal, the Department of Justice does not have the authority to legalize it.\textsuperscript{32}

\textbf{IV. Case Law}

The fraud and abuse statutes have been fleshed out with case law. It was the broad applicability of these statutes which generated the need for some safe harbors.

Case law sheds light on some of the scenarios previously outlined. In \textit{United States v. Duz-Mor Diagnostic Laboratory, Inc.},\textsuperscript{33} a proposal of a fifteen percent rebate in exchange for Medicare and Medi-Cal\textsuperscript{34} business constituted a bribe or kickback as outlined in federal statutes. In this case, Duz-Mor was a clinical laboratory certified as a Medicare and Medi-Cal provider. A Federal Bureau of Investigation (FBI) agent, posing as a spokesman for potential nursing home investors, proposed to refer Medicare patient laboratory services to Duz-Mor for financial remuneration. Duz-Mor characterized the taped conversation as preliminary negotiations, not a bribe. The Court ruled that Duz-Mor's suggestion of a fifteen percent rebate in exchange for Medicare referrals met the standards of an offer of bribery. Similarly, in \textit{United States v. Fekri},\textsuperscript{35} an offer of a ten

\textsuperscript{28} Id. at 19-20.

\textsuperscript{29} \textit{DEPT. HEALTH & HUM. SERV., HEALTH L. DIG. SUPP., pt. 1-2} (1985).

\textsuperscript{30} Id., pt. 1 at 4.

\textsuperscript{31} Id., pt. 2 at 2.

\textsuperscript{32} Id., pt 2 at 3.

\textsuperscript{33} U.S. v. Duz-Mor Diagnostic Laboratory, Inc., 650 F.2d 223 (9th Cir. 1981). (Fifteen percent rebate in exchange for Medicare business deemed a bribe or kickback).

\textsuperscript{34} Medi-Cal is the term used to designate the California medicaid program of reimbursement for low-income families. California participates in the federal Medicaid medical assistance through Medi-Cal. See 42 U.S.C. § 1392, \textit{et seq}. Funding is through the federal Dept. of Health & Human Services.

\textsuperscript{35} U.S. v. Fekri, 650 F.2d 1044 (9th Cir. 1981). (Rebate inducing laboratory referrals constituted kickback).
percent cash rebate on Medicare and Medi-Cal collections and discounts on private pay patient’s bills as an inducement to refer laboratory work to National Lab was deemed a kickback scheme. This case, on appeal, centered around the issue of entrapment. The court upheld the conviction stating that the government did no more than create an atmosphere where the defendant laboratory would feel comfortable discussing an illegal act.

A later case, *United States v. Greber*, was even more strict in its determination that fraud was present even if only a portion of the payment to the physician was an inducement and the bulk of the payment was compensation for professional services connected with tests performed by the lab. In *Greber*, the defendant was an osteopathic physician, board certified in cardiology. He formed Cardio-Med, a company which provided diagnostic services to other physicians. One of these services was the rental of a Holter-monitor, a device which records a patient’s cardiac activity over a 24-hour period. Cardio-Med billed Medicare for the service and, when payment was received, forwarded a percentage to the referring physician. The defendant argued these were merely interpretation fees, and on appeal, argued that a professional services fee could not be deemed Medicare fraud. The Court disagreed, holding that if only one of the many purposes for the payment was to induce referrals, a violation of the Medicare statute was achieved. The Court also noted that kickbacks could take a number of forms other than cash, such as long-term credit arrangements, gifts, supplies and equipment, and the furnishing of business machines.

In *United States v. Hancock*, the Court specifically pointed out that “the potential for increased costs to the... system... is plain” and “these are among the evils Congress sought to prevent by enacting the kickback statutes.” *Hancock* revolved around payments made by chiropractors to laboratories performing blood tests. The chiropractors claimed the monies paid were handling fees for packaging, obtaining and delivering blood to the labs and interpreting the results. The term “remuneration” was added to the statute in the 1977 amendment to make it clear that even if the action was not a “kickback” in the sense that no service was rendered, payment could nevertheless violate the law.

In another case, *United States v. Porter*, the 5th Circuit Court of Appeals took a more narrow view of the term “kickback” and determined that “remuneration” was not included therein. Subsequent courts have viewed the more expansive language of the 1977 amendments to support the *Hancock* interpretation that kickback and remuneration are both

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36 U.S. v. Greber, 760 F.2d 68 (3d Cir. 1985). (Fraud present even if only a portion of physician payment constituted inducement for referral).

37 Id. at 71.

38 U.S. v. Hancock, 604 F.2d 999 (7th Cir. 1979) (Court cited potential for increased costs one of the evils Congress was trying to prevent.)

39 Id. at 1001.


41 U.S. v. Porter, 591 F.2d 1048 (5th Cir. 1979). (Court narrowed definition of kickback to exclude “remuneration”).
included within the prohibitions of the act. Needless to say, this also includes such practices as double billing (United States v. Lipkis). The Lipkis case involved the referral of lab work from Mobile Medical Group, a practice which provided mobile medical care to patients in halfway houses in southern California. Most of the services went to Medicare and Medi-Cal participants. Lipkis was charged with making a claim to Medicare for payment for blood handling services for which he had already been paid by Automated Laboratory Services. The court found that Automated was paying a kickback for referrals and that Medicare was then being billed a second time for the same services. Yet another example can be found in Feiler v. New Jersey Dental Assoc., a case involving fraudulent billing practices where a dentist waived a patient's co-payment when billing third-party payers and not disclosing the practice to the insurance carrier. This practice was deemed fraudulent because by billing for services at a rate higher than that which he actually charged his patients, he caused the insurer to pay more than they would otherwise be required to pay. In 1986, Griffin Hospital v. Commission on Hospitals and Health Care, involved the appeal of a commission order to adopt a budget which allegedly required it to use federal Medicare reimbursements to subsidize the health care costs of non-Medicare patients. The Court ruled that the purpose of the Medicare reimbursement system was to control the cost of the Medicare program to the federal government and to encourage hospitals to contain costs associated with Medicare patients. The Court failed to find that a purpose of these statutes was to

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42 See U.S. v. Tapert, 625 F.2d 111 (6th Cir. 1980). (Court of Appeals for Sixth Circuit adopted the interpretation of "kickback" used in HANCOCK and rejected that of PORTER).

43 U.S. v. Lipkis, 770 F.2d 1447 (9th Cir. 1985). (Court found Lipkis guilty of double billing Medicare for blood handling services which had already been paid for by laboratory).

44 Feiler v. New Jersey Dental Ass'n., 191 N.J. Super. 426, 467 A.2d 276 (1983). (Court considered waiver of patient's co-payment fraudulent when Medicare billed at higher rate).

45 If, in fact, an insurer only pays eighty percent of a charge and the dentist indicates his bill is $100, then he can collect $80. But, if he has already shared with the patient that he will accept eighty percent (or $80) as payment in full, then the insurer should only be required to pay $64. And, if this is the rule, then the Usual, Customary and Reasonable (UCR) fee is $80, not $100. The dentist thereby offers "free" dentistry while competing dentists require a $20 co-payment. A counter-argument that this billing method makes dental care more accessible to low income families, reduces dental neglect and ultimately results in an overall savings to insurers was deemed unsubstantiated and irrelevant by the Court. Id. at 436.


47 See id. at __, 512 A.2d at 203. The hospital, under the Prospective Payment Plan, claimed to have earned a profit of $1,754,000 from the treatment of Medicare patients during the 1984 fiscal year. The hospital claimed the Commission forced it to subsidize the loss of $1,655,000 caring for non-Medicare patients with its Medicare profits, thus depriving the hospital of the choice to use its Medicare profits in a manner the hospital deemed appropriate.
allow hospitals to "insulate" any profit made from treatment of Medicare patients from the state. The Court ruled, in fact, that the recipient of the funds may use the monies for any purpose, thus siding with the Commissioners.

Since Greber, three recent cases have supported stringent enforcement of the anti-fraud amendments, indicating that Greber was not an aberration. The intent to interpret the fraud and abuse laws broadly seems clear. In United States v. Kats, a clinic owner was prosecuted for an agreement with a laboratory to remit back to the clinic fifty percent of the Medicare payments the lab received for services provided to patients referred by the clinic. Kats argued, as did Greber, that the payments were made as compensation for services rendered. The Court upheld Greber stating that even if only one of several reasons for the payment was to enhance referrals, it was fraudulent. In other words, payment must be made for goods or services only.

In United States v. Bay State Ambulance, a hospital employee responsible for ambulance bids also had a financial relationship as a "consultant" with one of the bidders, Bay State. The employee also argued that payment was for services rendered. Here, as in Kats, the focus of the case centered around the jury instruction. The trial court refused to instruct the jury that a guilty verdict could only be reached if the employee compensation was "substantially over-paid." Instead, the court found the test to be "intent" of the payments. When such consulting agreements are not full time, very strict requirements become necessary to meet the exemption from criminal liability. Finally, in Smith-Kline Beecham Clinical Labs, three limited partnerships operated clinical labs in southern California with over 100 physicians participating. Ultimately, Smith-Kline Beecham agreed to a $1.5 million settlement rather than risk being permanently excluded from Medicare/Medicaid.51

The case law cited serves to point out that the government has a heightened concern relative to potential Medicare fraud and abuse violations. Enforcement efforts have been stepped up, and appellate court decisions have upheld these criminal convictions. Providers would be well-advised to re-examine existing arrangements in light of the outcomes of recent cases and should take these cases seriously when considering future arrangements between providers of health care.62

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48 U.S. v. Kats, 871 F.2d 105 (9th Cir. 1989). (Clinic owner guilty of fraud for a 50% rebate scheme involving patient referral to laboratory by clinic).
49 U.S. v. Bay State Ambulance, 874 F.2d 20 (1st Cir. 1989). (Court found intent of employee compensation was to solicit business, not mere compensation for services rendered).
50 Id. at 31.
52 Riley & Pristave, New Medicare Fraud and Abuse Court Cases, 3 Nephrology News & Issues 8, 18 (August. 1989).
V. PRESENT STATE OF AFFAIRS

The Greber decision and those which follow call into question long-standing business arrangements in the health care system. Of late it has become increasingly difficult to draw a meaningful line between legitimate business arrangements and practices deemed fraudulent as a result of the expansive language of the fraud and abuse statutes. Even legitimate business practices might nevertheless increase utilization or be considered payment for referrals—two activities the government wishes to bar. New incentives in the health care market encourage hospital-physician joint ventures. Yet this very alliance increases the likelihood that the venturing physician will increase his utilization rate at the joint venture hospital. Does this constitute fraud? There are two separate subsections of the statute. The first limits remuneration to induce referral of an individual and the second limits remuneration to induce the referral of a service, such as laboratory work.\textsuperscript{5}

In 1987, the Secretary of the Department of Health and Human Services (HHS) was directed to specify various payment practices which should not be viewed as kickbacks.\textsuperscript{4} This resulted in the Medicare and Medicaid Patient & Program Protection Act of 1987.\textsuperscript{5}

The resulting regulations were referred to as safe harbor rules. These rules were intended to guide providers and afford them a level of comfort when engaging in business practices which Congress did not intend to prohibit by the Anti-Kickback Statute.\textsuperscript{5} At the end of 1988, the Department of Health and Human Services published the Safe Harbor Rules\textsuperscript{5} only to withdraw them five days later.\textsuperscript{5} A month later, HHS issued a revised version of the rules,\textsuperscript{6} but that draft is still awaiting approval by the Department of Justice and the Office of Management and Budget.\textsuperscript{9}

The current draft of the regulations contains several recurring themes. Major emphasis is placed on referring physicians not being reimbursed for referrals. Secondly, remuneration may not exceed fair market value. Finally, agreements between hospitals and physicians should be in writing and must last for no less than a year. Had these safe harbors been in place, they could have afforded health care providers some comfort in dealing with physicians and in their efforts to pursue joint ventures.

The Medicare Prospective Payment System, introduced in 1983, was the first attempt to curtail the spiraling cost of health care by the federal

\textsuperscript{5} 42 U.S.C. § 1396 h (b)(2)(A) and (b)(2)(B) (1985).
\textsuperscript{7} Id.
government under the Medicare reimbursement system. For the first time, hospitals, regardless of cost, were reimbursed by the Medicare program at a predetermined rate. Those hospitals who could treat patients with a particular ailment for less than the set rate would make money and those hospitals who could not would lose money. Suddenly, hospitals were being forced into a fiscal straight jacket that ignored all exceptions and dismissed all excuses.

It should have come as no surprise that hospitals began to shift their emphasis from inpatient to outpatient services, using preadmission and post-discharge services, developing community outreach programs and strengthening referral patterns with physicians. To continue to serve their patients and ensure financial survival, hospitals established formal as well as informal linkages with physicians and other health care providers.

At the present time, these very relationships are being scrutinized. What hospitals thought to be legitimate business ventures are now subject to restraints by fraud and abuse statutes.

While it is true that the government health insurance policy has in general created cost-enhancing incentives, these recent regulatory efforts have, by some estimates, cost the government an even greater amount. With every new governmental scheme to increase cost containment, there have been corresponding adjustments made by providers of health care institutions. Many of these maneuvers have been challenged by the fraud statutes as violations. It appears that the provisions were not drafted with the new competitive marketplace in mind. Some of the new business arrangements, encouraged by the prospective payment system, are stymied by the broad language of the fraud and abuse statutes. This uncertainty is breeding chaos in the health care industry and making essential long term planning impossible.

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61 Id. The prospective payment system categorized illnesses into 470 diagnostic related groupings ("DRG"). A reimbursement rate was set by Medicare for payment to the provider hospital regardless of the actual cost to the health care institution for providing that care.
62 Id. The goal was to make the cost of health care uniform throughout the United States (with some regional cost-of-living differences) and to force hospitals to reduce costs by refusing to reimburse at greater than the predetermined DRG rate. Heretofore, hospitals were reimbursed by Medicare at their cost. This system, Medicare argued, provided little incentive for hospitals to cut the ever increasing cost of health care.
64 Id.
66 Id. at 692.
Prior to Medicare legislation, enacted in 1965, was a thirty five year period focused on public access to medical care much like the Hill Burton Act's focus on ensuring the availability of health care facilities to all citizenry. For some time, demand, not need, has been driving the system. "When medical care is produced and sold in a market system, its distribution parallels the class structure of society. Economic demands become the basis for use, creating inequities in access to health care, whereas equity would require that health need be the primary determinant of use."68

Despite this fact, proponents of public health insurance have suffered continuous defeat since the 1930's. In fact, Blue Cross was created by the American Medical Association and American Hospital Association to defeat national health insurance.69 The Federal government basically accepted "the role of banker for the health system."70 This soon proved to be an overwhelming burden and national health insurance continues to be an issue today.

VI. PHYSICIAN RECRUITMENT

A hospital needs to attract and retain competent physicians to care for patients requiring hospitalization. Physician recruitment practices are one of the areas where safe harbors could have a positive impact on the health care industry. A recent Jackson & Coker National survey of 788 hospitals showed that sixty percent of all hospitals recruit physicians.71 Therefore, the physician recruitment issue is one which should be on the minds of over half of the hospitals in this country. Recruitment can take on many forms, but generally it encompasses the following areas: income or revenue guarantees, loans or loan guarantees, assistance in practice management, consultation or marketing, referral programs, assistance with relocation and financial assistance in the form of grant or loan forgiveness, signing bonuses, or contracts for administrative services.72

However, despite the fact that sixty percent of the hospitals recruit physicians and that half a dozen forms of questionable recruitment techniques exist, no regulations were contained in the January 23, 1989 proposed safe harbor regulations.73 Drafts of this legislation carried the

69 McDowell, supra note 65 at 694.
70 Id. at 694-695.
72 Id. at 2.
73 Id. at 4.
following conditions: (1) Benefits cannot be conditioned on referral of patients to the recruiting facility; (2) Benefits cannot be given for more than two years and no re-negotiation is permitted during that time; (3) The recruiting hospital cannot bar a physician from establishing privileges at another health care facility; (4) If the agreement includes the payment of malpractice insurance, that coverage cannot be limited to coverage solely of the recruiting hospital; and (5) Hospitals may not recruit a physician who has been practicing in the hospital service area for more than one year.74

Since drafts included these restrictions and the final proposed regulations did not contain a physician recruitment safe harbor, how are hospitals to know what conduct is acceptable and what is not? Inconsistencies abound. An example of these inconsistencies is that the Office of Program Integrity (OPI) states that payment to a hospital to promote the utility of hospital services is not illegal if the amount of payment is not related to the number of patient admissions or tied to a requirement that physicians admit to that hospital.75 The Internal Revenue Service (IRS), on the other hand, takes the position that a physician recruitment subsidy is not considered private inurement if the subsidy is reasonable and linked to the value of the contribution the physician will make to the hospital.76 It almost becomes a question of which agency is better to offend, the Justice Department, the IRS, the OIG or the Office of Program Integrity. Prudent health care administrators should choose none of the above. Certainly the IRS would not be the offended agency of choice. Problems with the IRS can jeopardize the tax exempt status of the hospital. The physician involved can also have income tax implications. Further, tax problems may affect future relationships among parties. If a hospital is a tax exempt charity under 501(c)(3),77 it may jeopardize its tax exempt status by recruiting physicians. To maintain a tax exempt status, a hospital must prove a charitable purpose, a public purpose and show that no earnings from the institution inures to any private shareholders or individuals.78 It is not always clear which approach the IRS will use — the benefit to the community analysis or the private benefit analysis.

Two cases, one in 1980 and one in 1989, look at the qualitative versus the quantitative aspects of this issue, American Campaign Academy v. Commissioner79 and Western Catholic Church v. Commissioner 80 In both,
the IRS was unconvinced by written agreements and looked to the actions of the entities to determine fitness. Both quantity and quality are necessary to benefit from tax exemption. In a private ruling, the IRS looked to the needs of the community. In addition, the IRS has consistently allowed greater latitude with rural communities where it is more difficult to recruit and retain physicians. Some recruitment incentives have been allowed by the IRS, but again the issue is a lack of clear-cut guidelines which results in a chilling effect on all recruitment because no health care institution wants to jeopardize their 501(c)(3) status.

VII. JOINT VENTURES

In reviewing joint ventures, the IRS evaluates involvement of the 501(c)(3) charity with taxable entities by considering in general whether the hospital's charitable purposes will be compromised. All facts and circumstances are reviewed. There is no per se loss of status. Some factors considered include: (1) Is there a substantial furtherance of purposes; (2) Does participation as a general partner create a conflict between 501(c)(3) obligation under the state partnership law to benefit the financial interests of the other partners versus an obligation under 501(c)(3) to effect charitable goals.

In 1982, the IRS stated that the exempt organization must be the sole managing partner or take a totally passive role. More recently (1986) a 501(c)(3) organization was allowed a more active role if the terms of the relationship insulated the general partner from any obligation in conflict with exempt goals. Another factor is whether the terms of the agreement protect the financial interests of the 501(c)(3) charity against greater benefits flowing to the non-exempt partners. In all of these factors, the threshold consideration remains: what is the relationship between the related purpose and the exempt purpose.

In all fairness, it is the very aspects of joint ventures most attractive to health care institutions that are aspects which represent the greatest risk of exposure under Medicare and Medicaid fraud and abuse. By joining forces, the members of a joint venture secure increased access to the market and increase the potential of their collective profitability. This profitability sometimes translates into increased utilization of health care services and expenses accruing to the Federal Government via Medicare and Medicaid. One of the major reasons for safe harbor rules is to make

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51 Eiland, supra note 71.
52 See, e.g., Rev. Rul. 73-313, 1973-2 C.B. 174, which justifies lower than market rentals in isolated rural areas.
53 Id.
54 Id.
55 Id.
56 Id.
it more difficult to assert a defense of inadequate intent. Defendants must "knowingly and willfully" participate in the activity.\textsuperscript{87} Therefore, if prosecuted for this offense, prosecution must feel that they have proof of clear intent, thus making ignorance a more difficult defense.

Clearly there is a trend toward greater enforcement. All the focus and interest on this aspect of Medicare and Medicaid reimbursement shows that the Federal Government is serious about its efforts to squeeze out all "fat" in the system.

Some experts are advising health care administrators to brace themselves for possible challenges to their tax-exempt status.\textsuperscript{88} Challenges may come from national, state or local levels for hospitals to show that their charitable and community services in some way compensate for tax dollars forgone by the community.

Senator Edward Roybal (California) has recently reintroduced a bill which requires hospitals to provide uncompensated care equal to at least fifty percent of the value of their tax exemption.\textsuperscript{89}

Advice on meeting this challenge to tax-exempt status includes knowing the law and documenting services. Industry leaders suggest the creation of a charity care policy, two years of free care documentation which includes the ability to separate out bad debt from charity care, the realistic assignment of a value to services rendered and, finally, communicating those services and the price for providing them, to the community the hospital serves.\textsuperscript{90} A recent consumer study of hospitals shows the public's perception of hospitals is hazy. A majority of consumers do not think hospitals are charitable organizations. If left uncorrected, these misconceptions can erode hospitals' standing with lawmakers.\textsuperscript{91} For example, according to a survey of 1,000 households nationwide, more than seventy percent say that the government and taxpayers pay for charity care while only 2.6 percent say that it is the hospitals which pay for the uninsured.\textsuperscript{92} There is much work to be done to underscore the identity of the not-for-profit hospital.

\textbf{VIII. STARK BILL}

A recent proposal toward even more stringent control of hospitals comes from HR. 939 sponsored by Peter Stark.\textsuperscript{93} This bill would increase the scope of activities subject to penalties and would impose additional re-

\textsuperscript{87} 42 U.S.C. § 1395 nn(b)(2).
\textsuperscript{89} News at Deadline, HOSPITALS, March 5, 1991, at 8.
\textsuperscript{90} Lumsdon, supra note 88, at 24-25.
\textsuperscript{91} Hospitals Tackle Image Problems at Many Levels, HOSPITALS, March 5, 1991, at 24.
\textsuperscript{92} Id.
\textsuperscript{93} CEOs Cautioned to Watch Stark's Referral Bill, HOSPITALS, Jan. 20, 1989, at 60 [hereinafter CEOs Cautioned].
striictions on safe harbors when physician referrals are involved. Safe harbors would remain the same for non-physician activities. In a joint venture, (1) hospitals would have to have a valid business purpose, (2) the joint venture would have to involve risk, that is, not be a "sure deal" participation in a joint venture because of a decline in referrals, (5) there must be a good-faith disclosure to patients or patrons so that they are aware of the relationship between the parties and (6) the joint venture must serve only non-medicare and non-medicaid patients. Yet another condition to the Stark Bill would restrict how payments would be made. The conditions require the services actually be performed, that these services would be performed even without the joint venture, and that the person performing the service must be right for the job - that is to prevent a physician from perhaps performing a billing function. Further, the payment to the physician must not be contingent on referrals, and finally, the payment must be the equivalent of fair market value. The Stark Bill would most certainly insure that the distribution of profits would not be linked with referrals. Clearly there is a commitment to rout-out and eliminate sweetheart deals between hospitals and select physicians who effectively control the flow of services to patients and over-use the services in the process. Stark's Bill, entitled the Ethics in Patient Referrals Act, has placed the health care community on notice that abuses will not be condoned. However, Stark has been accused of "basically working backward" for the sake of discussion. All agree, however, that the key is to produce a bill narrowly worded so as to only reach abusive situations and not unduly curtail legitimate referrals which result in the continuity of care and serve patients' best interests. Stark focused on diagnostic and therapeutic radiology, clinical laboratories, durable medical equipment and home health care in his introductory comments regarding the bill. The original draft also seemed to be overbroad in that it would restrict a physician referral to an entity which paid that physician more than $10,000 annually. This would prevent a medical director of a radiology department from referring a patient to his own employer-hospital. Most would agree that this is stringent. However, rules must certainly clarify the enormous gray area which is between what is clearly allowable and what is not.

Stark's very goal is to provide a bright-line rule which would restrict almost all Medicare referrals by physicians who had an interest in the provider receiving the referral. Stark seems to feel that the Government

95 Id. at 20.
96 Id.
97 Id.
98 CEO's Cautioned, supra note 93, at 60.
99 Id.
is a victim of clever deal-makers who have circumvented more generic statutes by simply disguising their schemes as legitimate business arrangements, also known as joint ventures. Stark sees three major evils lurking in these cozy arrangements. First, the physician may not refer the patient to the health care facility that will offer the patient the best care. Second, the interested physician may refer the patient for costly unnecessary services which increase Medicare costs. Finally, Stark insists that honest competition is thwarted when hidden payments become a cost of doing business. A further fear is that charitable assets could be diverted to the physician and no longer be available to serve the institution's stated charitable purpose.

Some find appeal in the bright-line approach, which explains what one can and cannot do in relatively straightforward terms and which would affect all equally. It appears that the more devious the hospital, the more protection it receives from the murky statutes on the books today. This could save hospitals from their stiffest competition of all, physician-owned entities.

Only a narrow substitute provision of the Stark Bill was enacted in 1989. Effective January 1, 1992, referrals to clinical laboratories where the referring physician has a relationship, will be prohibited. Also, all providers of Medicare services must have reported to the Secretary by December 19, 1990, all ownership arrangements connected to referring physicians. In addition, all Medicare Part B claims must carry the name and provider number of the physician. This allows a data base to be compiled of all physician ownership. The Comptroller General was to report the results of such a study to Congress by February 1, 1991.

Undaunted, it is possible that Congressman Stark will reintroduce the portions of his bill that were not included in the budget reconciliation agreement because he believes that doctors continue to reap benefits from Medicare due to unnecessary care referred to facilities where they enjoy part-ownership. Some would argue these restrictions infringe upon physicians' right to contract and their freedom of association. Stark assumes doctors will put their ethics on a shelf when it comes to ownership interests. This certainly is not true throughout the industry, but specific guidelines could go a long way to remove those lingering doubts about referrals and the true need for services rendered.

IX. TAX ISSUES

The hottest issue at present seems to be physician recruitment by tax-exempt providers. Once the IRS and OIG begin to share information

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100 Sullivan, supra note 3, at 79.
101 Id.
102 Id.
103 Id.
104 MacKelvie, supra note 9, at 4.
between potential violations of the fraud and abuse regulations and tax-exempt status rules, the charitable aspect of health care organizations will be examined under a microscope. Any private benefit accruing to an individual as a result of the 501(c)(3) charitable organization must be incidental to an overriding public benefit. Since 1909 there has been a statutory prohibition against inurement of net earnings from not-for-profit corporations to private individuals. This is so because financial benefit is deemed the same thing as the exercise of control.

The IRS has long considered hospitals as "physicians' workshops", and as such, imputes a certain degree of personal interest in the hospital to the doctor. This must be offset by the benefit realized by both the hospital and the community from physicians who practice near the hospital. The IRS has divided its view of these relationships and sees "benign" bonding relationships acceptable because they support the hospital's goal of efficient use of resources. The other view places the hospital in jeopardy if the physician is deemed to possess a relationship found to be of private benefit.

The IRS employs a test comprised of three prongs to decide the effects on the tax-exempt hospital: (1) Does the partnership serve a charitable purpose, (2) Does the partnership allow the hospital to further its exempt purpose; and (3) Does the agent confer benefits to for-profit persons.

In reviewing a hospital's tax exempt status, one must keep in mind that the providing of health care is not a criteria listed to support 501(c)(3) status. Tax exempt standards were not even established until 1956. Noteworthy in those initial requirements was the mandate that the hospital must be operated to the extent of its financial ability for those not able to pay for the services rendered. This became known as the "financial ability standard" and reflected the IRS' position that providing health care, per se, was not a charitable act. To be charitable, the hospital had to provide uncompensated care. The rule was found difficult to apply and in 1959 the regulations were altered to expand the term "charitable" to include purposes established by judicial decision. In 1969, yet another standard was substituted: the "community benefit standard" which recognized the principle that health care is a charitable purpose in and of itself. This removed the requirement of providing uncompensated care.

Today the community benefit standard applies. It is not considered to be met when a substantial portion of a community's residents are turned away if unable to pay. This has basically translated into a requirement of operating an emergency room open to all, regardless of ability to pay.

105 Id. at 5.
106 Id.
107 Id.
108 Id.
108 Sullivan, supra note 3, at 67.
110 Id.
112 Sullivan, supra note 3, at 69.
This is essential because many indigents cannot afford private physicians and an emergency room is their sole access to medical care.

Another community benefit requirement is non-discrimination of Medicare and Medicaid patients. If a hospital has a policy of turning away Medicaid patients because reimbursement is inadequate, the question can be raised as to whether it is in fact operating its hospital for the benefit of the community.

There is currently a blurring in some people's minds between non-profit and for-profit hospitals. In fact, Congress has requested that a study be performed by the General Accounting Office (GAO) to compare relative community benefit between tax exempt and for-profit hospitals. Based upon those results, the criteria necessary for hospitals to maintain their tax exempt status may become more stringent.

Hospitals need not stand idly by awaiting the outcome of the GAO study. The mandate appears clear: not-for-profit hospitals must provide enough community service to justify their tax-exempt status or convert to for-profit before that very result is thrust upon them.

Yet another regulatory action was introduced by the Office of the Inspector General (OIG) in a report to Congress entitled Financial Arrangements Between Physicians and Health Care Business. Over 1,100 health care providers were included and the results do not bode well for relaxing the regulations which target joint ventures. Among the findings were the confirmation that many physicians do have an interest in the health care entity to which they refer their patients and some physicians, in fact, own such entities. Even more revealing is the finding that patients of physicians who own or have a financial interest in laboratories receive more services than the average Medicare patient.

The OIG also sent to 1.5 million health care providers a "Fraud Alert" which described features of joint ventures which were considered suspicious under the Fraud and Abuse Statute. It even included a hot line number. Suspicious features were divided into three areas as they pertained to investors, business structures and financing, and profit distribution.

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114 Id.
115 Id. at 70.
116 Id.
119 Id.
120 Id.
At the Fifth Annual Health Care Tax Law Institute on May 2, 1989, an Assistant Chief Counsel for the IRS announced that the IRS and OIG will begin cooperating in an effort to identify areas of mutual concern relative to not-for-profit health care providers. Finally, the General Accounting Office issued a report in June of 1989 to the House Committee on Ways and Means which appeared to mirror the conclusions arrived at by the Office of Inspector General.

X. EVOLUTION OF HEALTH CARE POLICY

The need for across-the-board access to health care is again on the agenda of state and federal legislators. Competitive pressures, along with the regulatory changes, have all but forced physicians and hospitals to band together. Unfortunately, these new relationships result in shared assets which raise tax as well as public policy issues, because a hospital’s future is so inexorably tied to its medical staff. Informed estimates place seventy to eighty percent of all health care expenditures under the control of physicians. This is why hospitals continually strive to recruit and retain the best possible physicians. Much of the present concern surrounds the fear that these hospital-physician arrangements make it difficult to ensure that charitable assets are used for the public purposes so intended.

Now concern is enhanced because of the expanded authority of the Department of Health and Human Services. The 1987 Medicare and Medicaid Patient and Program Protection Act provided for civil sanctions. Many arrangements were protected in the past because they were not deemed severe enough to necessitate criminal prosecution. Now, the Health and Human Services Secretary cannot only prosecute a health care provider but can exclude that provider from participating in Medicare and Medicaid.

The problem with joint ventures, regardless of whether they involve inpatient care activity, is the motivation for the joint venture. When the hospital engages in a joint venture to maintain physician loyalty, that translates into an effort to ensure continued referrals. This, in turn, suggests the presence of inurement to the physician. Hospitals generally counter with the argument that physicians provide the necessary capital to finance the operation. However, most physician-hospital joint ventures are not capital intensive. In many cases involving sophisticated equipment, the manufacturer ensures financing.
Most joint ventures, despite protestations to the contrary, are based on fear. The fear is that the physician will move to a competing hospital and take all of his referrals along as well. So, despite warnings to the contrary, hospitals continue to joint venture, hoping that they will escape the ever widening net being cast by the IRS and its companion regulatory agencies.

One bright spot is Plumstead Theatre Society v. Commissioner, in which the tax court held that the Society was exempt notwithstanding its general partnership in a limited partnership along with private individuals as well as a for-profit organization. However, the IRS looks carefully at private benefit in a joint venture between taxable and non-taxable parties. The stakes remain high with the price being the loss of the hospital’s tax exempt status.

The IRS seems to have established two categories of review: one a threshold question, the other a more in-depth review. The threshold question is “whether participation by the exempt entity furthers its exempt purposes.” Second, the IRS closely examines the arrangement to see if it allows the not-for-profit entity to exclusively further its stated exempt purpose. The IRS looks for improper safety provisions against financial loss or financial gain.

There are five examples of ventures the IRS would not approve: (1) new obligations in conflict with not-for-profit purpose, (2) disproportionate shifting of profits or losses to the for-profit partners, in this case physicians, (3) a not-for-profit entity making unreasonable loans to the joint venture (i.e. unsecured or below market interest rate), (4) a not-for-profit entity turning over assets for less than fair market value or (5) the physician receiving the lion’s share of the profits.

While these examples are somewhat illuminating, they still must be viewed under tax laws as well as fraud and abuse laws and this is where things become confusing. The question becomes, “how much is too much?” Clearly, direct payments for referrals is prohibited, but the industry is currently so enmeshed in this joint venture scenario that it is almost impossible to stop. Since all hospitals are fighting for survival, each hospital fears that its refusal to play along with all the other hospitals in trying to bond physicians to them will result in their hospital being the one to close its doors. The ultimate victim of this problem is the health care system itself.

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128 Plumstead Theatre Society v. Commissioner, 74 T.C. 1324 (1980), aff’d per curiam, 675 F.2d 244 (9th Cir. 1982) (Court held Society exempt as general partner in limited partnership with private individuals and for-profit organization).
129 Id.
130 Sullivan, supra note 3, at 77.
131 Id. at 78.
XI. CONCLUSION

It is anticipated that once safe harbor regulations are published, enforcement will increase. Certain agencies are already revising guidelines to instruct their staffs more clearly. Meanwhile, the intertwining of fraud and abuse law with tax law has become the focus of the IRS and the Department of Health and Human Services. These agencies will certainly develop opportunities to share information.

One area deserving of close attention is the community benefit standard under which hospitals qualify as a 501(c)(3) charitable organization. Hospitals must benefit the entire community or risk the loss of their exempt status. Further, the IRS code is designed to protect a hospital’s charitable assets. If there is any question that these assets are being diverted to private interests, the IRS will not allow it.

The past decade has been unkind to non-profit hospitals. Charitable contributions have diminished, cost-shifting to payers has been curtailed and cost-based reimbursement instituted. This, along with a general decline of in-patient services, has forced hospitals to compete with each other, physicians and free-standing facilities. This new environment has caused hospitals to adapt by recruiting, retaining and rewarding physicians and the patient base which they control. It is clear that only the strongest and most efficient hospitals will survive. The Prospective Payment System encourages hospitals to see more patients in their hospital while providing them fewer services over a shorter period of time.

It is estimated that over sixty percent of privately insured Americans are covered by managed care plans (HMO’s, PPO’s and fee-for-service requiring pre-authorization for admission). This leaves very few “full pay” patients left. In 1988, the average hospital’s operating margin shrank by fifty percent from the year before to five percent in the first half of 1988.134 All agree that hospitals are now paying the piper for the building boom of the 1960’s and early 1970’s. Many hospitals that have recently closed cite several reasons including declining admissions due to lack of physician referral, a change in patient preference, increased patient mobility, declining revenue, uncompensated care burden, rising costs of plant maintenance, cost of new technology and nursing shortage.135

Not only must hospitals cut costs, they must increase revenue. That often translates into improving market share. Hospitals have been threatened by physician groups developing their own joint ventures and siphoning off profitable treatment programs like radiology. Hospitals have banded together thinking there is safety and strength in numbers. Meanwhile, physicians have not been curtailed as hospitals have. They still charge on a fee-for-service basis, thus still having no incentive to treat efficiently.

133 Id. at 66.
134 Id.
135 Id.
In this area, a not-for-profit hospital has a special burden. For a hospital to survive, it must at least achieve the following:

First, there must be complete documentation. This ensures that the correct questions are asked in the first place and shows the government that every option was fully reviewed.

Second, the Board of Trustees must have the correct and necessary information to make an informed decision, be it on recruitment, retention or joint ventures.

Third, in a physician relationship of any kind, the hospital must emphasize the program benefits to the hospital and to the community. This must occur without any unreasonable benefits flowing to the physician.

Fourth, the hospital must de-emphasize the benefits to the physician via loans versus income guarantees, for example. There is also a three year maximum on benefits for new doctors under the proposed safe harbors.136

Fifth, care in joint ventures must be exercised. There must be a bona fide business purpose, and investors must be chosen for reasons other than their ability to refer. All parties must have duties and responsibilities similar to a real business arrangement. Physicians cannot be given a small risk or be guaranteed a lopsided large return. All dividends must be based on investment units, and not on referrals. Most importantly, the hospital must keep an eye out for the IRS.137 It also helps to document the community need for the physicians. Safe harbor regulations require all agreements be in writing. Things become infinitely easier if the physician is an employee rather than an independent contractor. A bona fide employment relationship precludes a private benefit issue. Compensation must still be reasonable, however, to avoid problems.

Be reminded also that the actions of an affiliate can be imputed to the parent, so a separate corporation does not necessarily insulate the hospital. In other words, a hospital cannot with impunity do indirectly what it cannot do directly.

In conclusion, safe harbor regulations have failed to produce clear answers and guidance to hospitals. In two critical areas, physician recruitment and joint venturing, hospitals may be vulnerable because of their major reason for striking such deals: to induce referrals. However, there is still room for recruitment and joint ventures which are beneficial to patients and cost effective. In physician recruitment, hospitals must identify a valid business purpose for their recruitment program. If no referrals are required to be made to the recruiting institution, and a valid business purpose is shown, it will be difficult to show abuse.

136 MacKelvie, supra note 9, at 7.
137 Id.
Similarly, joint ventures must be proven to do more than enrich those who control the flow of patients and services. A hospital must make sure to impose a reasonable level of risk on the physician in a joint venture. Perhaps the most critical element is in the payment structure. Payments must be made on the basis of ownership interests.

More uncertainty is sure to follow, even after the long awaited enactment of the Safe Harbor regulations. The industry must sensitize itself to these issues in anticipation of greater scrutiny to come.

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