

# Chapter 10

## Practice Organizations and Joint Ventures

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Throughout much of the twentieth century, fee-for-service solo practice characterized the medical delivery system in the United States.<sup>1</sup> At the dawn of the twenty-first century, this type of medical practice had diminished in importance, replaced primarily by health care delivery systems that emphasize large, physician contracting groups or the “vertical integration” of physicians, hospitals, other health facilities, and related health care providers.<sup>2</sup> Managed care, the dominant method for financing and delivering care, is largely driving this change, prompted by technological advances, the glut of specialist physicians, and health care costs, which soared through the 1970s and 1980s but seemed to subside in the mid-1990s coincident with high managed care penetration.<sup>3</sup> Meanwhile, increased educational debt and an inability to participate adequately in managed care on an equitable basis have made it more difficult for the individual practitioner to enter or maintain the solo practice.

In the 1970s and 1980s the insurance industry responded to employer demands for manageable health benefit costs by developing new products and introducing methods of controlling costs for services covered under conventional insurance plans. These included discounted fee-for-service organizations, such as preferred provider organizations (PPOs), and payer devices, such as prospective payment, concurrent review, and second opinions. The 1990s saw an explosion in managed care as delivered through health maintenance organizations (HMOs), particularly in response to the Health Security Act proposed by President Clinton in 1993.<sup>4</sup> Federal and state governments acted to limit their financial liability under Medicare and Medicaid by limiting fee increases and increasing utilization and quality assurance reviews. In response to these forces, physicians are organizing, along with other providers, in arrangements designed to help profitably deliver high-tech, quality health care at funding levels now forcefully controlled by government and employers.

To participate in these new arrangements, physicians have restructured the way they practice. In addition to using partnerships, sharing arrangements, group practices, and multiple specialty groups, physicians are developing joint venture contracting arrangements, joining physician-hospital organizations, or forming practice management

companies. Grouping physicians in large practices, whether fully integrated for all practice purposes or in joint ventures for some limited purposes, often leads to economies of scale not achieved by a solo practice. Technology has permitted the development of outpatient surgery, imaging, lithotripsy, mammography, laser, and walk-in medical centers. Joint ventures between those who have the ability and willingness to fund such facilities and those who know how to manage them have played a key role. Physicians have banded together and invested in various types of outpatient centers, although such activity has been sharply circumscribed by federal legislation in the 1990s, limiting the types of investments referring physicians can make in such ventures.<sup>5</sup> The resulting physician practice arrangements are designed to maximize delivery and price efficiency in the managed care environment.

### PRACTICE ORGANIZATIONS AMONG PHYSICIANS

The physician may be an owner, shareholder, employee, or independent contractor of a practice. The form such practice takes is designed to accommodate physician and business needs.

#### Solo Practice, Sole Proprietor

The simplest form of physician practice, although increasingly rare, is the solo practitioner, sole proprietor form.

##### Advantages

The physician is free to establish professional relationships as necessary to create a practice environment.

##### Disadvantages

As with any other proprietorship, the owner is personally responsible for the liabilities of the business on a personal level. This includes liability for local, state, and federal medical regulations (e.g., occupancy and use, medical licensing, tax, provider reimbursement requirements), as well as all regulations controlling a regular business. The legal disadvantage of the sole proprietorship is the personal liability of the owner for business losses, debt,

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and negligence. The practical disadvantage to the sole proprietorship form is the difficulties inherent in coverage and participating with any degree of control in sophisticated managed care contracting arrangements.

### Sharing Arrangements

Sharing arrangements are associations between two or more physicians in which they share office space, equipment, and possibly employees. They may also share coverage of hospital and office patients on a rotating basis or when one or the other is not available.

#### Advantages

Sharing arrangements permit shared overhead expenses, allowing the participants to attain economies not available in a solo practice. Depending on the arrangement, it may permit shared capital expenditures and relative savings in rent, salaries, fixed costs such as utilities, and assured coverage. A sharing arrangement can exist between solo practitioners who are incorporated or unincorporated. The physicians involved may be partners in ventures that provide services to their individual practices, such as real estate and computer equipment. It has much of the advantages of solo practice while diluting the disadvantages.

#### Disadvantages

The practices may become so interlocked that to the general public the physicians are regarded as partners and not as solo practitioners. Legally, this means expanded liability for what may be deemed a de facto partnership. Failure to maintain separate employees, records, and billing may be introduced as evidence that there was no separation of medical practices. Liability may not only be extended from one practice to another for day-to-day business dealings but also in the event of medical negligence.<sup>6</sup> In addition, poor planning of the arrangement at its inception, as well as the lack of a clear and comprehensive agreement, will lead to trouble. The ground rules of the sharing arrangement must be established at the time of its creation and be reflected in a contract. Purchases (if jointly made), employee benefits (if shared), lease responsibilities, and other aspects of the arrangement must be defined.

Any employee-sharing arrangement may lead to complex benefit plan questions. For example, it may not be possible for one physician with a generous retirement plan to share an employee with a second physician, when neither the second physician nor the employee has any retirement plan benefits.

### Partnership

As defined in the Uniform Partnership Act now adopted in various forms by 49 states, a partnership is an association for two or more persons to carry on, as co-owners, a business for profit.<sup>7</sup> The "partner" may be a legal entity such as a corporation. A partnership is contractual in nature but is regulated and controlled by the partnership statute of a given state. Being contractual, the parties may structure

the relationship to suit their specific needs. The partnership agreement should spell out the relative duties and obligations of the partners. The agreement should cover the right to manage, operate, and share profits and losses.

Partners have several fundamental rights unless specifically otherwise stated in the agreement: (1) equal participation in the management of the partnership business and (2) majority voting rules. Other than in a limited partnership, or by agreement of the parties, profits and losses are shared equally and, theoretically, no partner can draw a salary. Salary is, in reality, profit.

If not created for a specific period, any partner can terminate a partnership at any time. The death of a partner terminates the partnership unless arrangements have been made to carry on the business in surviving partners' names. Loss of a partner can be chaotic to the business, and the partnership agreement should foresee this eventuality.

#### Advantages

A partnership provides the device for sharing overhead, arranging formally among the partners to share comprehensively all aspects of their business, and pooling capital. Other advantages include equal management, control, and shared profits.

#### Disadvantages

The tax consequences, rights and obligations, and liability of a partnership should be assessed before its formation. Being a partner in a general partnership carries certain rights but also creates obligations and liabilities. A general partner is personally responsible for the actions of his or her partners if those acts were made within the scope of partnership business. This extends to professional negligence, as well as commitments for equipment and loans. The partners are also personally responsible for business losses. For these reasons, it is important to determine the reliability of potential partners before entering this type of business arrangement.<sup>8</sup>

### Corporation

Unlike a partnership, which can be maintained even without a formal agreement or filing, a corporation is strictly a creation of statute. It is an entity with a defined business purpose that comes into being only after a formal filing. It is created by one or more individuals pursuant to statute to act as the legal representative of those individuals who contribute to its formation or become shareholders in the entity. Most states allow the formation of a *professional corporation*. This subspecies of corporation permits a licensed professional to form a corporation to engage in the business of practicing medicine in those states that would otherwise forbid such practices by regular business corporations. The definition of a professional or description of who can incorporate this type of business is contained within the appropriate state statute.<sup>9</sup> Professionals who incorporate generally form professional corporations, which may also be designated as *professional associations* or

*service corporations* (SCs). One or more physicians can form professional corporations.

The major difference between a corporation and a partnership is the degree to which a participant may suffer personal liability for the acts of colleagues. A partner has unlimited personal liability for all partnership losses whether he or she individually incurred them or not. In a corporation, losses are limited to the extent of investment; only rarely can personal assets be touched. A professional corporation is equally liable for the acts of its physician employees in the event of medical negligence, just as any company is liable for the acts of its employees. For this reason, professional liability policies are written in the name of the individual physician with supplemental coverage for the corporation. Thus in the event of a suit for medical negligence, both physician and corporate assets may be at risk if the award or settlement exceeds insurance policy limits, but not the personal assets of fellow physician shareholders.

The physicians should explore asset management at the time of corporate inception. A shareholder is not responsible for the ordinary business losses of a corporation, and a corporation may be dissolved when liability exceeds assets without prejudice to its shareholders. Tax treatment is another major difference between a partnership and a corporation. Partnership profits and losses accrue to the personal tax returns of partners, but, unless a corporation elects Subchapter S status (now available<sup>10</sup> to corporations with fewer than 75 shareholders who have only one class of stock), the corporation will pay a tax on profits before distribution of dividends. Those professional corporations usually define all net revenue as salary paid out by the corporation, not profit, to avoid this result on a normal yearly basis.

The corporate form does not offer all the technical "loophole" protections that it is often thought to offer. At one time, corporations could deposit a greater percentage of salary into a pension plan than could an individual. This anomaly was rectified by the Tax Reform Act of 1986. Separate corporations cannot be maintained and controlled by physician owners that would have the effect of cutting off rank-and-file employees from the employee benefits, such as the pension plan, enjoyed by the physician owners.<sup>11</sup>

### Advantages

Limited personal liability, possible benefit plans, certain tax breaks, and continuity in the event of the death of a shareholder are some advantages of incorporation. The practice is also more salable if it possesses a corporate name and life outside its existing individual physician founder.

### Disadvantages

Forming a corporation involves double taxation and significant difficulties in a tax-advantaged sale of the physician practice (unless the corporation has elected Subchapter S status) and in the maintenance of the corporate entity (e.g., minute books, records, attorney fees).

## Limited Liability Company

Starting in 1994, physicians in many states had the opportunity of forming their practice as a limited liability company (LLC). LLCs are recognized in virtually every state, but not all states recognize the right of an LLC to perform medical services.

The LLC was specifically designed to take advantage of the type of tax treatment available to partnerships (where profits and losses flow directly through to the owners) while providing the type of liability shelter that is typically identified only with corporations. This type of entity, by the late 1990s, was rapidly becoming the entity of choice for physician joint ventures formed for the purpose of managed care contracting.

### Advantages

The LLC offers the advantage of a single level of tax at the owner level with the highest degree of protection from liability for the acts of fellow owners. Further these taxation benefits can be obtained, unlike in the S corporation, regardless of the number of owners or classes of ownership.

### Disadvantages

Case law is not well developed with respect to LLC disputes. LLC formation is more involved, and the governance mechanism is less familiar to most physicians. Costs are generally higher for the maintenance of an LLC than for a corporation. Also, if an LLC decides for business purposes to retain capital in a particular year instead of distributing it to the owners, the owners will still be credited with the receipt of such monies and will be taxed accordingly.

## Independent Contractor

A physician may choose to provide services as an independent contractor to an individual physician, a professional corporation, health care institution, urgent care center, or any other practice setting available. This is a contractual relationship in which the physician generally has no equity interest. The services may be provided on a continuous or temporary basis.

### Advantages

No commitment to office space or overhead mobility, a fixed work schedule, and fixed income on an hourly, daily, or weekly basis are some of the advantages of being an independent contractor.

### Disadvantages

The independent contractor may be expendable, may be uninsured, and has no permanency to his or her practice situation. The relationship is strictly a matter of contract between the parties, so lack of a written agreement clarifying the parties' intention is a serious mistake. The issue of medical negligence insurance should also be examined carefully. The agreement should specify who will provide and pay for the insurance. Generally, if one is engaged as

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an independent contractor by a *locum tenens* agency, malpractice insurance will be provided. If an independent contractor appears to operate in a manner more often associated with employees, the Internal Revenue Service (IRS) may characterize the physician as an employee, triggering a series of negative tax consequences for both parties. A series of common law tests are available to make this determination.<sup>12</sup>

### Employee

Increasingly, physicians are starting or remaining in practice as the employee of an institution, another physician, medical group, or other practice setting. The key part of this relationship is the contract between the parties, which should address salary and benefits, incentives, liability insurance (and prior acts or "tail" coverage), termination, requirements for hospital privileges, and restrictive or noncompete covenants.

### Advantages

The employment relationship is often strengthened by rights spelled out in a contract. A contract is a written expression of the agreement between two parties. Both independent contractors and employee physicians are sometimes faced with the same problem. Because they lack an equity position in the practice, clinic, office, or other health institution, such physicians may have a difficult time negotiating language sufficient to protect their position in the community, as well as liability and income. Such physicians must understand, however, that the contract is the ultimate definition of the working relationship between the parties and that generally, oral understandings not expressed in the contract's "four corners" will not be taken into account. Before starting a long-term relationship, an employee can test the good faith of his or her employer by seeking clarification of a number of issues. The contract should at a minimum specify responsibility for insurance coverage, tail insurances, and termination. The individual employee's objective should be to protect himself or herself from termination, just or unjust, without malpractice tail insurance coverage.

The written agreement may also include a noncompete clause or restrictive covenant, which restricts a departing physician from seeing patients he or she previously saw through the employer. The validity of these covenants varies with the jurisdiction. From the employed physician's viewpoint, if inclusion can be avoided, it should be omitted, although from the employer's viewpoint, it may be a nonnegotiable part of the deal. For an employed physician, if inclusion cannot be avoided, it should be limited as to when it will apply, and a cash buyout formula should be defined in the agreement.

## MANAGED HEALTH CARE

Provider services were traditionally delivered to the health care consumer on a direct fee-for-service basis. Even physicians who were hospital based or employed generally billed

the consumer directly. With the advent of the federal government as payer through Medicare, for patients 65 and over, and with the expansion of third-party insurance coverage to employees as part of a negotiated pension and benefit package, the traditional financial relationship of provider and patient evolved.

For many decades, from the 1930s and 1940s through the 1970s, insurance simply paid the lion's share of the physician's charge directly to the physician on a claim assigned to him by the patient, and the patient paid the remainder. By the late 1970s and 1980s, however, government and employers stepped in to create an alternative system, one where they could manage the product to reduce costs rather than allowing consumers to choose and pay directly for services. The pervasiveness of these alternative delivery methods, spurred largely by the payers and, most significantly, HMOs, PPOs, and their progeny, gradually eroded the ability of the physician to control what was paid for his or her services and where those services were performed. It even changed, in many cases, whether the patient could continue to see his or her own physician. What used to be called "alternate and managed health care delivery systems," because it was the alternative to the standard indemnity approach, has become the standard itself and today is simply known as "managed health care."

The dominant forms of managed health care are HMOs and PPOs. These organizations introduced prepayment and negotiated fees for service as an alternative to traditional fee for service. The HMO is generally a prepaid plan whereby primary care providers are paid on a monthly capitated basis for each enrollee, who in turn pays a relatively nominal coinsurance payment for medical service. The PPO is a provider group, traditionally assembled by an insurance company but today increasingly organized by physicians or entrepreneurs, that provides services on a discounted basis to the consumer.<sup>13</sup>

### Health Maintenance Organizations

The term *health maintenance organization* was first coined by Dr. Paul Ellwood in the mid-1960s.<sup>14</sup> The Nixon administration pushed federal legislation and financing during the late 1960s and early 1970s, which enabled HMOs to gain a national foothold.<sup>15</sup> National membership in HMOs has grown to approximately one quarter of the population.<sup>16</sup>

An HMO is an integrated health care delivery system that combines the traditional financial risk of a health insurer with the hospital and physician service delivery responsibilities of a provider network. The HMO presumes it can contain costs by limiting hospitalizations, specialty referrals, and procedures and shifting some financial risk to the provider. It sells insurance coverage to consumers on a premium basis and attempts to create a provider network that is both competent and cost-conscious. The goal in assuming the financial risk is the delivery of quality health care to the enrolled consumer at a controlled and predictable price. To do so, the HMO usually contracts with providers on a per capita basis for primary care and a discounted

basis for diagnostic and specialty referrals. To enforce the system, many plans use a “gatekeeper” concept in which the primary care provider determines whether specialty or diagnostic referral is needed. Consumer self-referral is generally excluded from coverage.

HMOs generally structure themselves on one of five models for delivery of physician services: staff, independent practice association (IPA), group, network, and mixed.

### Staff Model

HMO-owned clinics staffed by physician employees are known as staff model HMOs. Such models are increasingly rare. Cost savings in this model are achieved by fixed provider costs and HMO ownership of hospitals and ancillary service centers. Control of these cost centers increases profitability for the plan as a whole by decreasing referred, inpatient, emergency department, and diagnostic costs.

### Independent Practice Association

This model has two categories. In the first category the IPA may consist of providers, such as primary care and specialist physicians, assembled as a provider group by the plan, who contract individually or by group to provide services. These services may be paid on a fee-for-service or discounted basis but increasingly are paid on a per capita, or capitation, basis. In *capitation* the provider is paid on a per member, per month basis in advance of delivering care. The IPA in this case consists of a physician panel that is assembled by the HMO.

The second category, provider-created IPAs, represent and negotiate contracts for the group as a whole with HMOs. The IPA is composed of individual practitioners and group practices. Physician-controlled HMOs and IPAs raise significant issues under antitrust law. These providers may substantially control the market, as reflected by their large market share. Even when such groups are small, they may have been seen as an illegitimate joint venture of physicians that attempts collectively to set a fee-for-service price for its physicians without benefit of any form of clinical integration; this is a criminal violation of the antitrust laws (see later section on joint ventures).

### Group Model

In this model an HMO contracts for services with independent practice groups; the basis for the contract may be either discounted fees or capitation in exchange for exclusivity. Hospitals, diagnostic centers, surgicenters, and urgent care centers may be arranged on a similar basis for services not provided by the group. Although price fixing within an independent group is not possible and therefore not an issue, size can be, particularly where the HMO is primarily controlled by its relationship with a single group.

### Network (Primary Care) Model

In this form, primary care providers are assembled in a network that serves as the provider panel. The primary care physicians serve as gatekeepers paid on a capitation basis who limit referrals to hospitals, specialists, and diagnostic centers.

The HMO sometimes contracts for specialty services, and sometimes transfers “full medical risk” for medical service delivery to the group, which in turn subcontracts with specialists. Less commonly, the HMO may contract through such a group for “full risk,” including hospital services, and the group will subcontract for both specialist and hospital services.

### Mixed Models

The mixed model may be any combination of the preceding systems. This system is more complex to assemble, but it may allow an HMO to tailor services to a specific market need.

HMOs employ various methods to control costs. The first method limits covered services for enrollees to a specific provider network. The second method requires a copayment, which is usually nominal. The third method limits services to the primary care physicians, the so-called gatekeepers who determine whether specialty referral and diagnostic testing are necessary. The HMO contract with patients or “subscribers” denies these individuals the right of self-referral. Additionally, the contract between the HMO and providers tends to put the providers at financial risk for overutilization of services. These services may be diagnostic tests, specialty referrals, or hospitalizations. In some cases the contract creates a holdback amount of about 10% to 20% of the capitation, discounted, or fee-for-service rate. Often the HMO will also create a pool or budgeted account for diagnostic testing and hospitalizations. If the primary care physician has a low referral or utilization rate at the end of each quarter or year, the HMO may share a portion of savings from this budgeted account in a bonus to the provider.

### Preferred Provider Organizations

PPOs evolved as another form of managed health care. An HMO is considered an integrated managed health care system in that it assumes risk for patient care. It integrates the financial aspects of an insurance company and the health delivery dimension of a provider network. In contrast, the PPO deals only with health care delivery; it is not an insurance company. This permits the PPO to escape most of the state, federal, and insurance regulations that apply to an HMO. The PPO contracts with physicians who deliver services on a discounted basis. The employer or administrator of the PPO is able to offer financial incentives to enrollees in the form of lower health care costs. The physicians, in turn, agree to abide by the utilization and quality assurance controls implemented by the PPO. The beneficiary is responsible for a deductible and coinsurance fee for services rendered. If the beneficiary sees a physician or obtains a service outside the panel, financial disincentives are imposed in the form of higher deductibles and coinsurance payment.

### Non-Hospital-Based Facilities

As coverage plans evolved and facilities providing care morphed from the one-dimensional world of the hospital

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to the multidimensional world of urgent care centers (walk-in medical centers), ambulatory surgical centers, diagnostic imaging centers, and freestanding laboratories, opportunities for physicians to be employees, independent contractors, or investors have increased. The advantage of being an investor, where not prohibited by law, is that the return on equity is related to the investment and thus generates passive income. An employee owner shares in profit in the facility as an investor, while also earning income on a fee-for-service or salary basis as a professional who provides services.

The issue of ownership and self-referral, however, is a problem for the health care industry, especially for the provider. The temptations for overutilization and overcharging are great. A physician-run laboratory is utilized about 30% to 40% more than a commercial non-provider-owned entity.<sup>17</sup> As a result, a number of states<sup>18</sup> have passed laws that prohibit referrals by a physician to a facility in which he or she has an interest, variously defined narrowly as an "ownership" interest or broadly as any "financial" interest (sweeping in debt, rentals, indirect ownership by relatives, and the like).

Most significantly, federal law now circumscribes a large variety of the types of ventures referring physicians may participate in as owners or, indeed, on any basis. The 1992 federal ban on physician referrals to clinical laboratories in which the referring physician has a financial interest outside their own office (*Stark I*) was expanded in 1994 to prohibit referrals for 12 designated health care services, including hospital inpatient and outpatient services, diagnostic services, and physical therapy (*Stark II*).<sup>19</sup> For the definition of what constitutes a "referral" and what constitutes a "financial interest" in such arrangements, Congress chose the broadest language possible.<sup>20</sup> As a result, Stark I and Stark II cast a large number of previously legal physician-related ventures into either clear illegality or the shadows of legal uncertainty. Before participating in any of these ventures, legal counsel intimately familiar with physician practices and the subtleties of the federal anti-self-referral ban must be consulted.

### Legal Considerations

PPOs and HMOs, as well as entities formed for the operation of a facility that provides an alternative to hospital-based care, have diverse ownership structures. They range from large, publicly held corporations to small, physician/investor-owned companies. To understand why these structures are chosen, it is essential to understand three related areas of law: the law of joint ventures, the antitrust law, and the general regulatory controls on the delivery and corporate practice of medicine.

## JOINT VENTURES

Changing patterns of health care utilization and reimbursement, along with increasing competitive pressures, have led to declining revenues and market share for both physicians and institutions. In an attempt to compensate

for these declines in both patient and cash flow, physicians, hospitals, and other types of health care providers have joined forces to prevent or reverse such losses through joint ventures. In recent years the joint venture has become a common method to capitalize on new opportunities in the health care market. Hospitals and physicians may need one another to form HMOs, PPOs, physician-hospital organizations (PHOs), and other associations that compete with commercial models. Hospitals often need physicians to be partners in outpatient ventures, including outpatient diagnostic facilities (e.g., magnetic resonance imaging [MRI] centers, mammography centers, other imaging services), urgent care centers, freestanding surgicenters, and freestanding rehabilitation centers, although the federal and state anti-self-referral laws have severely curtailed the numbers and types of such ventures. Because these types of ventures primarily need capital for construction and equipment, they could be built by hospitals, alone, without the joint ventures cooperation of physicians. However, the need for active physician participation in and commitment to providing services in the evolving health care delivery system often forces hospitals to reach out to physicians as partners.

Joint ventures among physicians, health care providers, institutions, and businesspersons are a growing phenomenon. The legality of these ventures depends on federal and state policies that regulate referral relationships and commercial competition generally. Each venture requires that both federal and state law be researched as to the venture's legality. Unfortunately, no clear law can be found and applied. Rather, extrapolations and analogies may have to be drawn from vague or loosely related statutes and cases. Ultimately, the joint venture may be forced to proceed on the basis of a series of educated guesses. A syndicated real estate venture might be legitimate, whereas a physician-owned MRI center may not, even though the venture involves the same two parties. Variations in state law make it extremely difficult to apply one type of experience to another state without adequate research into that jurisdiction's laws and regulations.

Rather than giving specific legal advice, which is impossible without reviewing all the facts of a particular venture, this section provides a primer for the creation of a joint venture.

### Definition and Characteristics

A joint venture is an association of two or more persons or entities that combine their resources to carry out a business enterprise for profit. This suggests creation of a new entity having managerial, financial, and productive capacity to enter or serve a new market. The agreement between the parties may establish a completely new entity or utilize preexisting entities to serve new markets or provide a new product. Creation of a completely new venture having independent management, facilities, and autonomy is generally advisable to avoid unnecessary legal and tax complications. The degree of independence enjoyed by the joint venture from either party is important in determining

whether the enterprise is a bona fide business. The bonafides of the business are important in determining the existence of fraud, individual liability, or corporate liability.

Joint ventures are created to meet hospital, physician, and business goals. Their main purpose may not be solely for capital formation. The reason why two parties may joint venture together, when these two parties have a referral relationship, is always subject to close scrutiny under the federal anti-kickback law, a criminal statute.

In addition to raising capital, hospitals may develop relationships with physicians, insurance companies, and others (1) to develop “new profit centers” within the hospital or in an outpatient setting; (2) to create alternative delivery systems to satisfy third-party payers; (3) to increase and enhance market penetration of the physicians and hospital; (4) to alter hospital-patient mix, limit debt financing, and increase community support for the hospital; and (5) to cement the relationship with physicians and other providers who support the institution. This list could be extended, but the goal is increased profitability by controlling costs, penetrating the patient care market on both an inpatient and outpatient basis, and securing the support of the local community and health providers.

Physician goals for entering joint venture agreements with one another or with hospitals include (1) entering new service areas, (2) creating outpatient facilities, (3) increasing or maintaining market share, (4) controlling costs, (5) sharing financial risk, and (6) participating in investment opportunities and acquiring capital management and marketing skills that might otherwise be more expensive to acquire. Joint ventures also allow physicians to invest and profit in areas that might otherwise be closed to them.

Joint venture permutations include physician-physician, physician-hospital, and realtor-physician. They range from life retirement centers to physician-owned laboratories and surgicenters. Because these ventures have increased in such numbers, the federal government, mostly through regulation of Medicaid and Medicare, has had the effect of limiting the access of physician referrers to certain investment vehicles. Increased capital requirements created by new equipment and treatment modalities have forced providers and institutions to reassess their relationship.

The six basic legal models for establishing joint ventures are (1) contract, (2) corporate (the traditional choice), (3) partnership (limited and general), (4) LLC (the form most often used in recent years because of its tax flexibility), (5) franchise, and (6) venture capital.

### **Contract Model**

The contract model is simplest, because the entire joint venture is contained within the four corners of a contract between the parties.<sup>21</sup> This could involve a service agreement lease, for example, in which physicians lease land from a hospital for the construction of a building that they then lease back to the hospital. In that example, the hospital does not have to contribute capital, and the builders have a leased building with a guaranteed rate of return.

No separate legal entity would be formed. Instead, the relationship is defined by the contract itself and is negotiated on the relative power of the joint venture partners.

The advantages to this form of joint venture are that it is simple to organize and understand, and it requires no new corporations or infrastructure. The contractual relationship is between preexisting entities. The disadvantage is that the contractual relationship creates new liabilities for the parties while lacking the near-permanence and additional protection that grow from the creation of an entity.

### **Corporate Model**

This model requires a corporate entity to be formed by the joint venturers, who will become shareholders. The joint venturers may be physicians, hospitals, or other investors. Individuals, corporations, or partnerships may own shares. Ownership need not be limited to physicians or hospitals.

The corporation acts through its board of directors. These joint ventures begin with a preincorporation agreement establishing terms of participation. The board has the day-to-day authority to run the business and set policy. The preincorporation agreement might describe the business plan, but it would not be incorporated into the bylaws of the corporation.

The corporation model results in a distinct legal entity that may expand on its own without further joint venturer participation or increased risk. The corporation will protect the investors from legal responsibility that exceeds their capital investment. The disadvantage to the corporation form, unless formed as a nonprofit organization, is that it is generally subject to double taxation. In addition, compliance with state and federal securities laws may be necessary before capitalization, increasing start-up costs.

### **General Partnership Model**

A general partnership is the association of two or more entities or persons who act as co-owners of a for-profit business. Profits and losses are equally shared unless otherwise agreed in the partnership agreement. The partnership agreement states the rights and duties of the partners. The partnership agreement specifies any arrangement the partners may wish to institute. The partnership is subject to the specific statutes of the state in which it is created.

The advantages of the partnership are single taxation and joint ownership and management. The major disadvantage is that each general partner is legally obligated to third parties for 100% of the losses, debts, and liability of the business as a whole.

### **Limited Partnership Model**

A limited partnership consists of at least one general partner with unlimited liability who is responsible for the management of the business. There can be one or more limited partner investors who have equity ownership with a liability potential limited to the amount of their investment, but who are not involved in the management.

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The advantages are similar to a general partnership; however, limited partners are not responsible for losses in excess of their contributions. General partners in a limited partnership may be incorporated, thus limiting liability to their corporate assets. Limited partners gain security and limit their losses but are barred from exerting day-to-day control over the business. Management participation of a limited partner may expose them to the liability of the general partner.

### Limited Liability Company

The LLC is the preferred choice for joint ventures among physicians, often seen in the development of physician networks formed for managed care contracting purposes.<sup>22</sup> An LLC protects participants from liability, just as a corporation does, but allows all revenues and expenses associated with the enterprise to be treated, from a tax perspective, as though the entity is a partnership.<sup>23</sup> Thus an LLC is usually regarded as closer to a partnership than a corporation.

This tax advantage is important. Particularly in an evolving health care market, where consolidation is rampant and where the likelihood of the LLC being subsumed or acquired by another entity is high, negative tax consequences from such sales must be anticipated.

Within an LLC, physicians may retain earnings, declare profits (and losses), or reap the benefits of sales proceeds without the double-taxation penalty. They may also create different classes of ownership interests and avoid any limitation on the size of membership. Further, a network of physicians could preserve its option of offering memberships to individual physician participants, as opposed to their professional corporations, without fear of exposing these personal participants to the liabilities of the entity.

An LLC may also be the choice of physicians and hospitals that co-venture certain projects, and this leads to one disadvantage when physicians venture with hospitals exempt from federal taxation. From a business perspective, there may be good reasons to retain LLC earnings in the venture for new costs or infrastructure. To a tax-exempt organization, there is no impact. To the tax-paying physician, however, those retained monies are deemed income on which tax is owed, even though the physician never actually received a distribution. This is the subject of ongoing tension in such ventures.

### Venture Capital Model

The most common venture capital approach to joint venturing among physicians, hospitals, and commercial interests currently may be found in management services organizations (MSOs), generally associated with hospitals but sometimes privately held, and physician practice management companies (PPMCs), usually associated with commercial investors or publicly traded companies. In both cases the management company purchases the assets of a physician's practice, including furniture, fixtures and equipment, and accounts receivable. It also purchases the obligation of the physician group and its individual

physicians not to practice elsewhere in competition with the venture. A physician's professional corporation remains intact, possessing only its employment relationships with its physician shareholders and physician employees, and their ongoing relationships and contracts to provide medical services. The management company then contracts with the professional corporation on a long-term basis (usually 20 to 40 years) to manage the professional corporation in exchange for some percentage of revenues, usually calculated in a specific formula designed to comply with state corporate practice of medicine and fee-splitting rules.

Because the management company does not practice medicine but solely maintains assets and purchases accounts receivable from the professional corporation on a regular basis through its management agreement, it is largely free of a wide range of state and federal regulations that might otherwise apply to a medical practice limiting opportunities for investor participation. As a result, everyone from hospitals to commercial financial houses to Wall Street may participate as a joint venture with physicians in their effort to become a larger and more sophisticated player in the evolving health care marketplace.

### Financing Considerations

State and federal interest in the nature of joint ventures and referral patterns may affect the type of venture and finance arrangements selected by the joint ventures. Stark I, Stark II,<sup>24</sup> and evolving tax law (particularly where a venture with a tax-exempt entity is concerned) have subjected physician joint venture to increasing governmental review. Arrangements where physicians "self-refer" to a service or facility where they have a financial interest are suspect. As a result, these laws may play a role in the way in which a venture is financed.

### Conventional Debt Financing

Debt financing takes the form of a loan payable in a specific term, a revolving line of credit, or a demand line of credit. In general, a loan involves a set amount, for a certain term with a specified rate of interest. It may be for interest only with a balloon payment or amortized over a set time. The interest may be specified or may vary according to a specified formula (e.g., prime rate).

### Bonds

Tax-exempt bonds issued by a state or a political subdivision of a state may be exempted from federal taxation. They generally are not tax-free in the state issued unless the state waives the right to tax the bonds. At least 75% of the bonds issued by the state or a political subdivision must be used in a tax-exempt trade or business, as specified in Section 501-C-3 of the IRS code.

Industrial development bonds are bonds issued to create nonexempt businesses, which are defined as entities with more than 25% of the proceeds used to finance nonexempt businesses. Tax-exempt status is determined on a case-by-case basis.

### Public and Private Equity and Debt Offering

Securities registration statements for a public offering must be filed, and the requirements are time-consuming and costly. Exemptions to the filing and disclosure requirements include insurers of securities, incorporators of businesses, and all offers of sales in which 80% of the sales, proceeds, revenues, and assets remain in one state for the first 6 months. Resales must be made within the same state 9 months after the sale. The aggregate offering price must be less than \$1.5 million, and the Securities and Exchange Commission (SEC) must clear the offering 10 days before the offer of sale.

Qualified private equity offerings are exempted from requirements to file a security statement. The requirements to qualify for the exemption are precise and statutorily mandated. The dollar amount must be less than \$500,000, regardless of the number of investors. Alternatively, the offering can be for less than \$5 million to 35 or fewer unaccredited investors and an unlimited number of accredited investors. An accredited investor must have a net worth exceeding \$2 million or a net income in excess of \$200,000 for the last 2 years. In some states an offering limited to less than 50 or 35 investors, depending on the state, may be exempt under state blue-sky laws.

### Venture Capital

Venture capitalists are risk-takers who gamble that a gain will be achieved by private or public sale of a newly established business. Venture capitalists only recently entered the physician segment of the health care industry in significant numbers, largely as a result of development of PPMCs. Previously, venture capitalists have assisted in starting up ambulatory health care companies in the 1980s. In return for their capital, they often assume a large degree of control and a preferred percentage of profits.

### Equipment Lease Financing

Equipment may be acquired for the purpose of leasing to a health care facility or medical practice. The facility may be a hospital, ambulatory care center, or physician's office or clinic. The advantages may be accelerated depreciation, guaranteed rent, and capital conservation for the lessee.

The terms of the lease financial arrangements, maintenance agreements, sublease, replacement, or acquisition by the lessee are all subject to negotiation as part of the contract, but may be subject to fair market value limitations when executed between referring parties.

## ANTITRUST CONSIDERATIONS

Antitrust law distinguishes between impediments to competition that are "horizontal" (i.e., between competitors) and those that are "vertical" (i.e., impede competition because a product has been tied up through a relationship between the various players that produce the product's components, such as the primary care physicians, specialists, and hospitals that, together, produce the inpatient hospital product). This section focuses primarily on horizontal issues, which most often arise in the development

of the new physician organizations that are responding to the evolution in managed care.

The key distinction between types of physician organizations pivots on the degree to which the organizations are "integrated" on the one end of the spectrum or "nonintegrated" on the other end, with degrees of integration or "partial integration" in between. A medical clinic that is a single professional corporation with multiple specialty physicians as employees is fully integrated. On the other end of the spectrum, an IPA that engages only in fee-for-service contracts and does not attempt to build any sort of joint clinical data operation is completely nonintegrated. Network joint ventures that negotiate fees with clinical integration; network joint ventures that negotiate risk-based contracts, such as capitation; PPMCs that manage a variety of professional corporations; and PPMCs that manage a single professional corporation provide increasingly greater, but not full, integration along the integration scale.

The key elements in determining the degree of integration are the extent to which previously separate organizations have combined their assets and the extent to which the previously separate organizations will combine their liabilities in the future. Certain specific attributes of integration may be important, such as the degree to which the parties share defined liabilities (e.g., risk under a capitation contract) or the degree to which the parties share defined assets, which may grow or evaporate depending on their collective performance (e.g., fee withholds under contracts performed by the group). Also important are the degree to which the participants in the combination have invested their own capital and the degree to which the venture participants intend to create new efficiencies through clinical integration (i.e., tracking information on all participants and using that information to reduce utilization, reduce costs, and increase profits or revenues to venture participants).

No horizontal entity can negotiate contracts on behalf of its members without first achieving the degree of integration required to avoid triggering the antitrust laws. Section 1 of the Sherman Antitrust Act prohibits contracts, combinations, or conspiracy in restraint of trade.<sup>25</sup> Physicians who are independent actors and who collectively negotiate for fees are engaged in a *per se violation* of Section 1, meaning that no further argument regarding the rationale for such behavior will be entertained by a court that is considering either the criminal or civil penalties for such behavior. These principles exclude traditional IPA fee-for-service agreements from collective negotiation.<sup>26</sup> Approaches have been developed to allow individual IPA members to opt into or out of such agreements, which are generally referred to as *messenger model* devices.<sup>27</sup>

However, physician joint ventures such as IPAs and networks that seek to negotiate non-fee-based contracts (capitation, global arrangements, substantial withholds), or such ventures that have sufficient clinical integration and desire to negotiate fee-based contracts, will not be subject to *per se* treatment but rather will be permitted to collectively negotiate such contracts if such collective

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negotiations are reasonable under the economic circumstances. This important development arose from the joint statements of the U.S. Department of Justice and the Federal Trade Commission (FTC) issued in August 1996.<sup>28</sup> The most significant and subtle development in those joint statements is the groundbreaking acknowledgment by the enforcement agencies that even fee-based contracts can be jointly negotiated by a physician group if the group is legitimate in its desire to integrate clinically and is not a sham group simply designed to maintain or increase utilization and prices. Finally, when all physicians are contained in a single, fully integrated group, there can be no fee negotiation difficulty under the antitrust laws. The group is a single actor, and violations of Section 1 can occur only when two or more parties or entities combine or conspire to violate it.

Even fully integrated groups, however, could violate the antitrust laws if they are large enough to exert market power. For example, physician mergers in which “all the doctors in town” are involved might be prohibited if their effect “may be substantially to lessen competition or tend to create a monopoly” under another important antitrust law, the Clayton Act.<sup>29</sup> Even joint ventures, such as physician networks, are subject to this prohibition. As a result, the FTC and the Justice Department identified market shares of physicians that, in joint ventures, will never create a cause for concern. If physicians formed groups that include a larger percentage of physicians than those identified in the joint statements (30% of the physicians in a particular specialty in nonexclusive groups), a “rule of reason” analysis would have to be conducted to determine whether such a venture was lawful.

Because of the imprecise nature of determining when a group has “market power,” the group’s “percentage of market share” is used as a rough rule of thumb for whether the group will have market power. This is a presumption that may, and should in the case of physicians, be rebutted. Commentators have consistently pointed out that market share is only one factor requiring consideration when determining market power.<sup>30</sup> Enforcement agencies have extensively refined their view of market percentages as an indicator of possible anticompetitive effects.

Enforcement agencies have stated that exclusive physician networks consisting of 20% or fewer of the physicians in each specialty with active hospital staff privileges who practice in the relevant geographic market and share substantial financial risk, or nonexclusive physician networks consisting of no more than 30% of such physicians, will not, absent extraordinary circumstances, be challenged by the agencies. To show that they do not believe networks should be limited to 30% of physicians, however, they have issued a series of advisory opinions and business review letters that have “blessed” networks with significantly greater than 30% market share.<sup>31</sup> As an important limit to the agencies’ willingness to bless sizable networks, they are particularly reluctant to bless networks where they believe that it is difficult, if not impossible, for competitors to enter the market.<sup>32</sup>

## REGULATORY AND RELATED CONSIDERATIONS

Joint ventures and medical delivery arrangement are affected by a wide variety of regulations. This section focuses on those unique to medicine.

### Licensure

Joint ventures may be organized between physicians and hospitals or by physicians alone. Freestanding urgent care centers or surgicenters may be organized and run solely by and for the benefit of the physicians who provide services, or they may be open to physician and nonphysician investors. These permutations may be determined by state licensing requirements.

A hospital-run facility may fall under the general licensing and certificate-of-need regulations (if any) of the particular state; each state’s statutes must be reviewed. In most states freestanding surgicenters, HMOs, and diagnostic facilities are highly regulated, whereas an urgent care center may be treated as a physician’s office, with little or no regulation imposed.

Regardless of the specific state regulations that regulate these centers, generally accepted legal precepts will apply. Each facility must be able to deliver the type and quality of services it advertises. The appropriate staff, equipment, and ancillary support services must be provided to maintain acceptable standards of care. Failure to maintain these standards opens the door to litigation not only with the physicians and entity but also with the investors.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has approved standards applicable to freestanding urgent care centers. Its *Accreditation Manual*, generally updated yearly, contains these standards. The National Association of Freestanding Emergency Centers has established the Accreditation Association for Ambulatory Care. This voluntary association provides an *Accreditation Handbook* that should be used as a guide to the establishment and management of freestanding urgent care centers. Standards are suggested concerning medical records, patient rights, and services provided by the facility.

### Insurance Regulations

Joint ventures may create insurance companies. Since the advent of HMOs, physicians, hospitals, and other joint venturers have joined forces, in many combinations, to provide health insurance plans to consumers. The HMO was the first and probably the most popular method of uniting physicians. By accepting the economic burden of the patients, the HMO falls under the jurisdiction of both federal HMO and state insurance regulations, and PPOs may also fall under the purview of the state insurance statutes. Regulation of PPOs is generally much less onerous than that applicable to HMOs and other types of insurance companies.

Although an HMO must comply with federal HMO legislation if it intends to become “federally qualified,” state law generally controls HMOs and PPOs. These laws impose reserve requirements, regulatory approval of the text of policies, reinsurance, and frequent and regular reporting to state agencies. The joint ventures may be unable to sell the product even if the business is in compliance with all regulations. As investors, the physicians and other providers have to maintain an arm’s-length relationship to avoid any questions of price fixing. The plan itself, whatever the product mix, may be compelled to offer certain types of benefit packages and may not be allowed to exclude or rate insured clients.

### **Tort Liability for the Enterprise**

There is a growing trend in the United States to hold organizations independently responsible for their acts. The concept of corporate negligence has begun to permeate the medical arena. As a result, PPOs, HMOs, hospitals, and other entities (e.g., laboratory services, urgent care centers, diagnostic centers) are potentially liable for negligence, regardless of provider affiliation.<sup>33</sup>

Additionally, there is the potential for employers and the insurance network to be liable, because patients in pre-paid plans are forced to select physicians from the panel chosen by the plan and indirectly by the purchaser of the insurance.<sup>34</sup> This expanded liability imposes on the joint venturers an obligation to follow through with credentialing, peer review, quality assurance, and risk management where required.

A further component of the problem is the limitation of care provided. The HMO and PPO tend to try to limit referrals and laboratory testing. Under the guidelines established by the joint venture, this may indicate a breach in the standard of care. As physicians, hospitals, health care providers, and venture capitalists enter the health care arena, their liability exposure mushrooms. In considering a joint venture with diversified services, the investor should explore the potential for personal liability. One way to limit loss exposure is to institute risk management programs. Florida was one of the first states to initiate mandatory risk management as a component of health delivery systems.<sup>35</sup>

The integration of internal utilization review, quality assurance, and risk management programs may decrease potential loss exposure. The Health Care Quality Insurance Act of 1986 created a national data bank for reporting physicians and providing data to certain organizations to credential physicians.<sup>36</sup> Failure to properly credential an individual could open the way for civil litigation based on failure to report or failure to query the data bank for information.<sup>37</sup>

### **Fraud, Abuse, and Ethical Considerations**

Medicare has prohibited the solicitation, receipt, or payment of any fee directly, indirectly, overtly, or covertly for

the referral of a Medicare or Medicaid beneficiary for a covered item of service, whether it be for goods, services, facilities, or other benefits.<sup>38</sup> The advent of physician-owned ventures has opened an area of potential abuse.

The Judicial Council of the American Medical Association has ruled that physicians can engage in commercial ventures, but they should be aware of potential conflicts of interest. If the physician’s commercial interest conflicts with patient care, alternative arrangements should be made.<sup>39</sup>

Stark I/II is designed to deal with the issue of physician self-referral. It reverses the burden of the fraud and abuse statutes, which require the government to prove illegal intent to refer or receive referrals for remuneration. Instead, it prohibits all referrals between financially interested parties unless they meet narrow exceptions, and it requires the physician to prove an exception has been met.

Legislation enacted in 1987 allows the inspector general of the Department of Health and Human Services (DHHS) to exclude a person from Medicare participation if he or she engages in a prohibited remuneration scheme. The act also required the secretary of DHHS to promulgate “safe harbor” regulations, which give physicians comfort that their referral relationships are legal. Legislation enacted in 1996 extends the reach of federal law into fraudulent health care billing in the commercial sector, making such activities a federal crime.<sup>40</sup> The growing use of “Qui Tam” actions, or whistle-blower lawsuits, has generated a new growth industry in litigation involving schemes for over-billing.<sup>41</sup>

In addition to the federal statutory prohibition on “fraud and abuse,” the careful planner of health care ventures must also consider the statutory and common law prohibitions on fraud that might be applied to any industry. Schemes to “kick back” money to a referrer of services or to seek payment without providing service outside the Medicare payment system might constitute fraud under a state statute.<sup>42</sup>

### **Corporate Practice of Medicine**

Corporations are generally prohibited from practicing medicine.<sup>43</sup> The standards established by a facility or other type of venture must reflect standards promulgated by health care providers and not by the partnership, corporation, or any other type of entity. The goal is to provide quality care while avoiding interference with the provider-physician relationship. The JCAHO and state, federal, and voluntary accrediting agencies strive to maintain provider control over standards of care.

Joint ventures may create managed health care entities, diagnostic facilities, treatment centers, or other types of health care delivery mechanisms. In each of these cases the role of the nonprovider manager and investor should be kept separate from the care delivered. To avoid pitfalls, the organization should structure the relationship of the providers, specify the type of facility, and delineate the responsibilities of the nonprovider managers and owners.

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### Ethical Considerations

The medical literature, legislative subcommittees, insurance carriers, and the public all question the entrepreneurial aspects of joint ventures among physicians, hospitals, diagnostic facilities, and treatment centers. The suspicion is that a system of self-referral will lead to overutilization with concomitant increases in health care costs.

The ethical and legal issue of fee-for-service medicine for patients at facilities owned by the referring physicians alone or in conjunction with another institution has been raised as a result of increasing health care costs.

### CONCLUSION

Increasing market competition and capital requirements have brought together different combinations of providers, hospitals, and business persons; however, their interests are not always the same.

The formation of a joint venture can subject investors to antitrust investigation, private litigation, state and federal enforcement activity, and increased exposure to negligence, both medical and corporate. In addition, investors may have ethical conflicts within their investor groups.

Increasing governmental intrusion affects the methods used to create a joint venture, with regard to both legal requirements and capital contributions. Nevertheless, the promotion of integrated services, the exploitation of new markets, and the provision of new and valuable services for the health care consumer present exciting challenges for physicians and hospitals.

### Endnotes

1. P. Starr, *The Social Transformation of American Medicine* (Basic Books, New York 1982).
2. Hermann et al., *Integrated Delivery Systems in a Changing Healthcare Environment: New Legal Challenges*, Monograph No. 1 (Forum on Healthcare Law of the American Bar Association, Nov. 1994).
3. Levit et al., *Health Care Spending in 1994*, 15 *Health Affairs* 130-144 (Summer 1996).
4. Health Security Act, H.R. 3600/S1757, Report No. 773, *Medicare and Medicaid Guide* (Commerce Clearing House, Chicago 1993).
5. 42 U.S.C. 1395nn.
6. *Insiga v. LaBella*, 14 Fla. L. Weekly 214 (Apr. 21, 1989).
7. Uniform Partnership Act, Am. Jur. 2D.
8. Uniform Partnership Act §18.
9. Fla. Stat. §607, Professional Service Corporations 766.101, 1988 (Florida); 805 ILCS 15/1 *et seq.* (Illinois).
10. Pursuant to the Small Business Administration Act of 1996, the number of eligible shareholders has increased from 35 to 75. In addition, certain charitable and other organizations can now be S corporation shareholders (the law used to limit shareholders to individuals only).
11. Internal Revenue Code, §414M.
12. Internal Revenue Code, §530, as modified by the Small Business Job Protection Act of 1996; *Riverbend Country Club v. Patterson*, 399 S.W. 2d 382 (Tex. Civ. App. 1965). The IRS, under its Audit Guidelines for agents, has also set forth a checklist of 20.
13. For a comprehensive listing of such organizations, see *Health Network and Alliance Sourcebook* (Faulkner & Gray, Inc., New York, <http://www.FaulknerGray.com/healthcare>).
14. *The Flowering of Managed Care*, Med. Economics (March 1990).
15. *Supra* note 1.
16. Pear, Congress *Weighs More Regulation of Managed Care*, New York Times 1 (March 10, 1997).
17. Mitchell et al., *New Evidence of the Prevalence and Scope of Physician Joint Ventures*, 268 J.A.M.A. 80 (1992).
18. For a detailed listing of current state law relating to physician self-referral prohibitions, see Mayo, *State Illegal Remuneration and Self-Referral Laws*, NHLA Monograph Series (National Health Lawyers Association, Washington, D.C. 1997).
19. Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, 107 Stat. 312 (1993). The designated services are physical therapy services; occupational therapy services; radiology, including magnetic resonance imaging, computed tomography scans, and ultrasound services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment, and supplies; orthotic and prosthetic devices; home health services and supplies; outpatient prescription drugs; and inpatient and outpatient hospital services.
20. "Referral" is defined as, in the case of an item or service for which payment may be made under Part B of Medicare, the request by a physician for the item or service, including a consultation by another physician and any test or procedure ordered by, or to be performed by, that other physician (or someone under his or her supervision). Additionally, *the request or establishment of a plan of care* by a physician that includes the provision of a designated health service constitutes a referral, 42 U.S.C. §1395nn(h)(5)(A)(B). (Emphasis added.)
21. Rosenfeld, *Joint Venture Organizational Models*, Twelve Topics in Healthcare Financing 38-44 (Winter 1985).
22. Rust, *Advice for the Doctor: the Formation of Single Specialty Networks*, 42 *Practical Lawyer* (Oct. 1996).
23. The authority for treating limited liability companies as partnerships for tax purposes comes from U.S. Treasury regulations that state that the classification of an entity as a partnership or an association taxable as a corporation depends on whether the entity has more corporate characteristics than noncorporate characteristics. The four relevant corporate characteristics are (1) continuity of life, (2) centralization of management, (3) limited liability, and (4) free transferability of interests. To be taxable as a "partnership," an entity must lack at least two of the four factors. See *Philip G. Larson*, 66 T.C. 159 (1976); *George Zuckman*, 524 F.2d 729 (Ct. Cl. 1975).
24. Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. 1961.
25. 15 U.S.C. §1.
26. *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982).
27. *United States of America v. Healthcare Partners, Inc., Danbury Area IPA, Inc., and Danbury Health Systems*, Civil Action No. 395-CV-01945 RNC, Sept. 1995 (definition of messenger model in final judgment action against independent physician association).
28. United States Department of Justice, Federal Trade Commission, *Statement of Antitrust Enforcement Policy and Healthcare* (Aug. 1996).
29. 15 U.S.C. §12-27.
30. Landes & Posner, *Market Power in Antitrust Cases*, 94 *Harv. L. Rev.* 937 (1981).

31. Letter from Ann K. Bingaman, Department of Justice, to J.F. Fischer (Jan. 1996) ("substantially more" than 30% of several specialties in a number of local markets, including more than 50% in one specialty); letter from Ann K. Bingaman to M.J. Fields (Dec. 1995) (44% of board-certified dermatologists); letter from Ann K. Bingaman to D. Hartzog (Oct. 1994) (up to 50% of chiropractors).
32. Department of Justice Business Review letter to Ted R. Callister (March 1996) finding that the Orange Los Angeles Medical Group, Inc. (ORLA), operating with in excess of 30% of the anesthesiologists in the defined market, may be challenged by the Department of Justice.
33. *Darling v. Charleston Memorial Hospital*, 211 N.E. 2d 253 (1966); *Pedrosa v. Bryant*, 677 P. 2d 166 (1984).
34. *Harrell v. Total Healthcare, Inc.*, 781 S.W. 2d 58 (1989). Court stated that an IPA model HMO owed a duty to its participants to investigate the competence of its panel members and to exclude physicians who pose a "foreseeable risk of harm."
35. Fla. Stat. 766.110, 395.041, 641.55, 624.501.
36. Pub. L. 99-660 (Nov. 1986); 42 U.S.C. 11101 et seq.
37. 42 U.S.C. 11135 §425(b).
38. 42 U.S.C. 1320a-7(b)(b).
39. *Report of the Judicial Council of the American Medical Association*, J.A.M.A. 2425 (Dec. 1984).
40. Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936 (1996). Subtitle E, §241 adds: "Federal health care offense" defining a new federal health care offense in the criminal code to mean a violation of, or conspiracy to violate, a number of provisions in the federal criminal code if the violation or conspiracy relates to a "health care benefit program."
41. Relief includes injunctive actions and the seizure of assets, 18 U.S.C. §1345(a)(1), (2).
42. *Supra* note 22.
43. Chase-Lubitz, *The Corporate Practice of Medicine Doctrine: an Anachronism in the Modern Healthcare Industry*, 40 *Vanderbilt Law Rev.* 445 (1987); *Berlin v. Sarah Bush Lincoln Health Center*, 279 Ill. App. 3d 447 (1996).

