

NETWORKS

Traditional physician practice arrangements, such as solo or small, single specialty group practices, have provided physicians with much-coveted professional autonomy, financial independence, and self-determination. However, health care reform, managed care, declining revenues, increased overhead expenses, and additional administrative and regulatory burdens, have caused physicians to consider alternatives. While remaining committed to the preservation of individual autonomy wherever possible, physicians often look for opportunities for developing strategic alliances with one another and with their hospitals. Physicians look to establish these relationships in order to increase influence with managed care plans, reduce practice costs, increase administrative efficiencies, and increase revenues. However, there are significant regulatory constraints, which must be considered prior to affiliation.

I. DEFINITIONS, LEGAL STRUCTURES, AND RELATIONSHIPS

A. Physician-Hospital Organizations and Independent Practice Associations. Organizations with the least impact on an individual physician's practice autonomy are physician-hospital organizations (PHOs) and independent practice associations (IPAs). A PHO is a legal entity formed by a hospital and physicians, essentially to contract with managed care plans, although other joint activities can and should be considered. An IPA is an organization of independent physicians, formed for similar purposes, and, sometimes, to serve as the physician member of a PHO. These organizations do not provide medical or hospital services directly, but arrange for the provision of such services through their members.

PHOs and IPAs seek to deliver a unified provider network to managed care plans. Accordingly, contracts with managed care plans negotiated by the organization seek to bind its members to participate in the contract. In order to protect its marketing and contracting capabilities, a PHO or an IPA may also wish to require its members to refrain for a period of time from negotiating independently with a managed care plan with which the organization is currently negotiating. Antitrust laws (discussed below) require careful structuring of these contractual obligations.

Some of the strengths of a PHO or an IPA include the physicians' ability to retain autonomy because these organizations do not impact their practice locations, ownership structure, or administration. In certain situations, a PHO or an IPA has provided a vehicle for organizing a medical staff dominated by solo or small group practitioners. These precise advantages, however, are also disadvantages: there is a low degree of physician-hospital integration, there is little change in economic relationships or incentives, and there is a lack of an information infrastructure.

B. Supergroups or Group Practices Without Walls. Depending on its level of integration, an organization may acquire some or all of the assets of several physician practices and employ all physicians (the fully integrated model), or may provide centralized administrative services only (the partially integrated model). In the partially integrated model, each physician or physician group retains its individual provider billing number, staff and equipment, and pays an annual fee for a series of defined services. In the fully integrated model, the group has a single tax identification number, the physicians share risk and capital investment, and the group determines compensation methodology, fringe benefits, and administration for all locations.

Supergroups are frequently a good approach for networking primary care physicians with specialists. Frequently, the motivation for forming a group practice is increased marketing appeal to third-party payors, recruited physicians, and managed care plans. Economies of scale from sharing certain administrative expenses or group purchasing arrangements are also cited, as well as the opportunity to develop ancillary services. The strength of supergroups is that the physicians retain some autonomy, although it is shared with other physicians. From antitrust and fraud and abuse perspectives (discussed below), the more fully integrated the group, the lower the risk of allegations of joint price setting or illegal remuneration from referrals within the group.

C. Medical Foundations. A medical foundation is a nonprofit, tax-exempt organization that provides medical services through employed physicians. Foundations are usually found in academic medical centers. Their governance and control structure typically mirrors that of the corresponding hospital department. The foundation may also acquire the assets of the physicians' practices, as long as the acquisition is negotiated at arms-length. The foundation supplies management, billing, purchasing, and other services to physicians. It may also contract with managed care plans.

The foundation has the advantage of being able to be capitalized through tax-exempt funding sources. It is also very appealing to payors because of its ability to align compensation incentives. The foundation, however, is very capital intensive in its startup and operational phases and does not provide the independence and autonomy of private practice.

D. Integrated Delivery Systems. An integrated health care delivery system is a single organization that provides hospital, physician, and other health care services to patients. This type of organization is a vertical network, often involving providers at different levels in the chain of delivery (i.e., community and tertiary hospitals, physicians, home health agencies, long term care facilities, and ancillary providers).

The organization may take several legal forms. It may be a single entity, either for-profit or not-for-profit. Alternatively, the entity may be an umbrella-type parent holding company, for-profit or not-for-profit, of which diverse health care organizations such as foundations, group practices, hospitals, and medical service organizations (MSOs) are subsidiaries. In this scenario, the medical foundation is often the first step toward an integrated health care delivery system. In many cases, the hospital is the controlling entity of the foundation or group practice. While the physicians may own and control the hospital, this is not typical.

Ultimately, the integrated health care delivery system may also offer its own HMO or other managed care product.

II. ANTITRUST

The purpose of antitrust laws is to protect competition. In the health care context, antitrust laws protect competition among providers for patients and for payor contracts, and among payors for members and provider contracts. These laws are an important force to be reckoned with in forming networks.

A. Restrictions. In the context of healthcare networks, antitrust laws prohibit collective action by providers and payors, attempts to gain monopoly power by driving rivals from the market, and mergers, joint ventures, consolidations, or acquisitions of stock or assets where the effect may be to substantially lessen competition or tend to create a monopoly.

Certain activities constitute per se violations because they pose such substantial harm to competition that the courts do not consider the reasonableness of the circumstances. Per se violations include agreements between competitors relating to price and allocation of customers, tying agreements where the entity imposing the tie has market power, and group boycotts where the group has market power.

Other relationships are judged by a more flexible "rule-of-reason" standard. Under this analysis, the courts examine the purpose, operation, and effect of the activity to determine whether it enhances or to inhibits competition or whether there are redeeming economic benefits to the arrangement. Rule of reason analysis permits arrangements where the procompetitive effects outweigh the anticompetitive impact.

B. Physician Network Safety Zone. The Department of Justice and Federal Trade Commission (FTC) has issued policy statements that created a safety zone for provider networks. If a network meets the criteria of a safety zone, it will not be challenged, absent extraordinary circumstances. There is a safety zone for exclusive physician network joint ventures comprised of 20 percent or less of the physicians in each physician specialty with active hospital staff privileges who practice in the relevant geographic market and

share substantial financial risk. For nonexclusive networks, the percentage is increased to 30 percent. In an exclusive arrangement, the member physician agrees not to participate in any other network and agrees not to enter separate contracts with payors. In a nonexclusive arrangement, a physician is free to participate in other networks and is free to enter separate contracts with payors.

The policy statements recognize the following four methods of sharing substantial financial risk:

- accepting capitated rates;
- providing designated services on a percentage-of-premium basis;
- providing financial incentives to achieve cost-containment goals, such as withholding compensation or establishing network cost or utilization targets, with physicians subject to rewards or penalties based on group performance in meeting targets; and
- charging global fees (fixed, predetermined fees for complex treatments involving coordination of care by physicians in different specialties).

Physician joint ventures that fall outside of the antitrust safety zone may still be acceptable under the antitrust laws. Such ventures will be reviewed under a rule-of-reason analysis and not viewed as per se illegal if the physicians' integration through the network is likely to produce significant efficiencies that benefit consumers, and any agreements that would otherwise be per se illegal are reasonably necessary to realize these efficiencies. Examples of such integration include an active and ongoing program to evaluate and modify practice patterns by the network's physicians and create a high degree of interdependence and cooperation to control costs and ensure quality, selective selection of network physicians likely to further these objectives, and significant investment in the infrastructure necessary to achieve these efficiencies.

When a network is not integrated, it should not negotiate price terms on behalf of its participating providers, but should serve only to communicate the price terms to each member provider. The network should use a neutral third party, such as an accountant or an attorney, as a messenger to collect price terms and other information privately from each of the physicians and compile the information. The physicians may not share this information with one another, and the messenger must not pass on any information received privately from one physician directly to the other physicians. The messenger should not negotiate terms and may not take responsibility for each provider's decision to accept the price terms.

C. Selective and Exclusive Contracting. According to the policy statements, a successful network will usually need to select among providers in order to achieve the level of integration and efficiencies required to enjoy safety zone protection. Accordingly, excluded providers have been largely unsuccessful in challenging a network's exclusion. Selective and exclusive contracting are not per se illegal unless the excluding network has market power.

III. FRAUD AND ABUSE

Fraud and abuse laws are enforced to prevent the potential for overutilization, unnecessary costs, inappropriate care, interference with patient freedom of choice, and arrangements that may reward or encourage referrals or otherwise present conflicts between clinical judgment and pecuniary interests. As networks are frequently formed for the purpose of facilitating referrals, developing ancillary services and streamlining operations, it is important that the networks are structured to be compliant with these laws.

A. Stark Law.

1. Prohibited Financial Relationships. If a physician (or immediate family member of such physician) has a financial relationship with an entity, the physician may not make a referral to the entity for the furnishing of any designated health services, and the entity may not present or cause to be presented a Medicare or Medicaid claim or bill to either program or any individual, third-party payor, or other entity for such referred or ordered services.

A financial relationship is defined as a direct or indirect ownership or investment interest in an entity through equity, debt, or other means or a compensation arrangement involving any remuneration, directly or indirectly, overtly or covertly, in cash or in kind, between a physician (or immediate family member) and an entity that provides designated health services.

A referral is defined very broadly to include services performed by the referring physician's employees, coworkers, and independent contractors. All such requests to others for items or services are prohibited referrals unless they are excluded by definition or fall under an exception.

Designated health services are the following:

- clinical laboratory services;
- occupational and physical therapy services (including speech-language pathology);
- radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound (not including nuclear medicine procedures);
- radiation therapy services and supplies (not including certain preventive screenings, procedures integral to and performed during a nonradiology procedure, and x-ray, fluoroscopy, and ultrasound services that are rendered as part of an invasive procedure such as cardiac catheterization or endoscopy);
- durable medical equipment and supplies;
- parenteral and enteral nutrients, equipment, and supplies;
- prosthetics, orthotics, and prosthetic devices and supplies (not including certain surgically implanted devices at ambulatory surgical centers (ASCs) and eyeglasses and contact lenses prescribed after cataract surgery);
- home health services;
- outpatient prescription drugs; and
- inpatient and outpatient hospital services, including services provided under arrangement.

2. Exceptions. The Stark Law includes statutory exceptions that permit certain physician financial relationships that would otherwise be subject to the Stark Law prohibitions. The Stark Law is intended to establish a "bright line" test for compliance; the very existence of a prohibited financial relationship, even if indirect, violates the law unless the relationship meets all of the requirements under an applicable exception. Accordingly, the Stark Law is a "zero tolerance" statute, and compliance with each element of an exception is necessary in order to avoid Stark Law sanctions.

Exceptions relevant to physician networks include:

- in-office ancillary services, which applies to referrals within a group practice of services ancillary to the referring physician's service;
- prepaid plans and risk-sharing arrangements, which applies to risk-sharing payments made to physicians by managed care organizations;
- academic medical center services, which is intended to address unique physician compensation relationships found within the academic medical center setting related to research, teaching and other administrative tasks;
- rental of office space and equipment;
- personal service arrangements, which address any remuneration paid by a physician by a DHS entity;
- bona fide employment; and
- fair market value compensation.

B. Antikickback Statute.

1. Prohibition. The federal antikickback statute prohibits any individual or entity from knowingly and willfully soliciting or receiving, or offering or paying any form of remuneration ("in cash or in kind") in order to induce the following:

- referral of an individual for the furnishing, or arranging for the furnishing of, any item or service payable under Medicare or Medicaid; or
- purchasing, leasing, ordering, or arranging of any good, facility, service, or item payable under Medicare or Medicaid.

Most states have also adopted antikickback statutes, extending the prohibition to all third party payors.

2. Safe Harbors. There are a number of regulatory exceptions to the broad prohibition of the antikickback statute, known as safe harbors. Unlike the Stark Law, failure to comply with a safe harbor does not necessarily mean that a relationship or transaction constitutes a violation of the antikickback statute. Rather, the activity falls into a gray area, and will be analyzed based on the facts and circumstances. Safe harbors relevant to physician networks include:

- investments in group practices;
- space and equipment rentals;
- personal service and management contracts;
- employment;
- electronic prescribing; and
- electronic health records.

IV. TAX

Tax-exempt organizations are frequent participants in networks and are bound by a number of requirements that must be considered in the formation and operation of networks with physicians.

A. Section 501(c)(3) Status. To qualify for a tax exemption under Section 501(c)(3) of the Internal Revenue Code, an organization must be organized and operated exclusively for “religious, charitable, scientific or educational purposes.” The benefits of tax-exempt status include exemption from federal income taxation and the ability to receive tax-deductible contributions or to obtain tax-exempt financing.

For a tax-exempt hospital that fully subsidizes the development and operations of a network, the activities of the network could be attributed to the hospital, and must be in furtherance of the hospital’s exempt purpose.

Section 501(c)(3) organizations may engage in unrelated business activities as long as the unrelated business income does not constitute a substantial portion of the organization’s income. A tax-exempt organization must pay tax on income derived from any trade or business regularly carried on by the organization that is not substantially related to the organization’s exempt purpose.

B. Private Inurement, Private Benefit, and Intermediate Sanctions. No part of the net earnings of a tax-exempt entity, such as a hospital, may inure to the benefit of a private individual. Private inurement exists when the person so benefiting is considered to be an insider or a controlling person with respect to the entity. If the IRS finds any private inurement, an exempt entity can lose its tax exempt status. There is no de minimis exception. On the other hand, private benefit exists when the person so benefiting is not an insider. A de minimis amount of private benefit is permissible.

Where excessive compensation is paid, there can be a finding of private inurement. In evaluating whether compensation is excessive, the IRS will look at whether the compensation arrangement is reasonable and is based on an arms length transaction, whether the amount of the compensation qualifies for an expense deduction, whether the compensation is really a cover for the improper distribution of profits, and the relationship of the parties involved.

The IRS may impose so-called Intermediate Sanctions, i.e., sanctions short of revocation of tax-exempt status. This law imposes substantial excise taxes on “disqualified persons” who benefit from an “excess benefit transaction” with a charitable or social welfare organization, such as a hospital. A disqualified person is one who is in a position to exercise substantial influence over the affairs of the organization. Unlike the private inurement rules, which consider all medical staff members to be insiders, physicians will be disqualified for purposes of the excess benefit law only if they are actually in a position to exercise substantial influence. An excess benefit transaction is one in which the tax-exempt organization, such as a hospital, provides a benefit to a disqualified person that has a value in excess of what the organization received for providing the benefit, including the value of services to be performed by the physician.

C. Compensation. Compensation arrangements between a tax-exempt organization and a physician, whether he or she is an independent contractor or an employee, must meet the following criteria:

- they must be reasonable, based on a comparison of compensation paid by other hospitals for similar services rendered by similarly qualified physicians;
- maximum compensation, including incentive compensation, should be set forth in writing; and
- compensation may not constitute a sharing of the net earnings of the hospital or any of its divisions or departments.

Successful networks are those which are able to negotiate collectively on behalf of network participants and demonstrate to participants as well as health plans that they are able to deliver care in an integrated manner. As the pressure mounts to move to capitated reimbursement arrangements, networks must have an infrastructure in place to measure performance, allocate resources among participants, provide cost and quality data and implement programs designed to control costs and increase quality. Given these daunting challenges, it can be expected that physicians will carefully consider network opportunities in order to affiliate with those best positioned to respond to a rapidly evolving healthcare market.