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EXECUTIVE SUMMARY



**BUSINESS LAW AND GOVERNANCE,  
FRAUD AND ABUSE,  
HOSPITALS AND HEALTH SYSTEMS,  
AND PHYSICIAN ORGANIZATIONS  
PRACTICE GROUPS**

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**Community Hospitals: A Discussion of  
Physician Recruitment and Retention Issues**

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*This is the first in a series of Executive Summaries dealing with the unique challenges facing community hospitals.*

A hospital's ability to successfully recruit and retain physicians depends on a host of factors, including the availability of financial resources from which to offer recruiting and retention arrangements, the ability to attract physicians in needed specialties, satisfying an increased demand by many physicians to have "guaranteed" incomes, and compliance with strict and complicated fraud and abuse laws. Community hospitals face all of these challenges, but do so with limited budgets and few, if any dedicated recruiting personnel. In addition, community hospitals, which are often located in rural areas, have to convince physicians that a smaller community provides similar professional opportunities (i.e., compensation) as compared with urban areas and that any shortcomings are offset by a better "quality of life." Despite these challenges or maybe because of them, community hospitals have available several unique options to help in their physician recruitment and retention.

## Key Terms

### *Community Hospital*

For this Executive Summary's purposes, a community hospital is defined as an independent, non-academic health system consisting of a small number of facilities (usually one or two) that provides general (non-specialty) health services to a specific geographic community.

### *Rural Area*

In many cases, a community hospital is located in a "rural" or "non-metropolitan" area, which are key terms in structuring physician recruitment and retention arrangements (as well as physician-hospital joint ventures) under the federal Stark Law<sup>1</sup> and the federal Anti-Kickback Statute.<sup>2</sup> A rural area is defined as an area *not* included in an "urban area." By regulation, an urban area consists of a Metropolitan Statistical Area (MSA) or a New England County Metropolitan Area (as defined by the Office of Management and Budget (OMB)), or certain specified New England counties.<sup>3</sup> Accordingly, a hospital located outside of an MSA or a

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<sup>1</sup> Ethics in Patient Referral Act of 1989, 42 U.S.C. § 1395nn, and its corresponding regulations at 42 C.F.R. § 411.350, *et seq.* (Stark Law). The Stark Law prohibits physicians from referring Medicare or Medicaid patients for certain "designated health services" (DHS) to entities with which the physician (or an immediate family member of the physician) has a financial relationship (either a compensation or an investment/ownership relationship), unless a Stark Law "exception" applies. The Stark Law also prohibits the entity from billing for services provided pursuant to a prohibited referral. There are ten DHS categories under the Stark Law, including inpatient and outpatient hospital services.

<sup>2</sup> The Medicare and Medicaid Patient Protection Act of 1987, as amended, 42 U.S.C. § 1320a-7b. The Anti-Kickback Statute makes it a crime to offer, pay, solicit, or receive remuneration directly or indirectly in return for referring an individual to a provider of services for which payment may be made in whole or in part under a federal healthcare program, including the Medicare or Medicaid programs.

<sup>3</sup> 42 U.S.C. § 1395ww(d)(2)(D); 42 C.F.R. § 411.351. The OMB defines metropolitan statistical areas according to published standards that are applied to Census Bureau data. The general concept of a metropolitan statistical area (MSA) is that of a core area containing a substantial population nucleus, together with adjacent communities having a high degree of economic and social integration with that core. See U.S. Census Bureau website, [www.census.gov/population/www/metroareas/aboutmetro.html](http://www.census.gov/population/www/metroareas/aboutmetro.html).

defined New England county will be classified as rural.<sup>4</sup> The U.S. Census Bureau website can be used to search for rural areas by county and location.<sup>5</sup>

### *MUP / MUA / HPSA*

A Medically Underserved Population (MUP), a Medically Underserved Area (MUA), and a Health Professional Shortage Area (HPSA) are terms used in the Stark Law and the Anti-Kickback Statute provisions addressing physician recruitment and retention. A MUP and MUA are populations or areas, respectively, designated by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) as having too few primary care providers, high infant mortality, high poverty, and/or high elderly population.<sup>6</sup> A HPSA is defined as an area designated as a health professional shortage area under Section 332(a)(1)(A) of the Public Health Service Act. HPSAs may be designated for primary medical care, dental, or mental health providers and can occur in both rural and metropolitan areas.<sup>7</sup> A MUA, MUP, and HPSA can be determined based on address, state, and/or county by searching the HRSA website, <http://bhpr.hrsa.gov/shortage/index.htm>.

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<sup>4</sup> 42 C.F.R. § 412.62(f)(1)(ii). An area that OMB has designated a "micropolitan statistical area" is considered to be outside of an MSA and therefore "rural" for purposes of the Stark Law. See 72 Fed. Reg. at 51012, 51042 (Sep. 5, 2007); Stark Law Advisory Opinion, No. CMS-AO-2008-02.

<sup>5</sup> See [www.census.gov/population/www/metroareas/metrodef.html](http://www.census.gov/population/www/metroareas/metrodef.html). "Rural" is also used in other government programs that might be of interest to community hospitals. The Rural Assistance Center has on its website, <http://maps.rupri.org/circ/racural/amirural.asp>, a searchable database to determine by city and zip code whether a location is rural for purposes of the following programs: Rural Health Clinics Program, Medicare Telemedicine Reimbursement Program, Small Rural Hospital Improvement Grant Program, Rural Access to Emergency Devices Grant Program, Rural Health Care Services Outreach Grant Program, Rural Health Network Development Grant Program, and Rural Health Network Development Planning Grant Program.

<sup>6</sup> See HRSA website, <http://muafind.hrsa.gov/>.

<sup>7</sup> 42 C.F.R. § 411.351. According to the HRSA, as of September 30, 2008, there are:

- "6,033 Primary Care HPSAs with 64 million people living in them. It would take 16,336 practitioners to meet their need for primary care providers (a population to practitioner ratio of 2,000:1).
- 4,048 Dental HPSAs with 48 million people living in them. It would take 9,432 practitioners to meet their need for dental providers (a population to practitioner ratio of 3,000:1).
- 3,059 Mental Health HPSAs with 77 million people living in them. It would take 5,145 practitioners to meet their need for mental health providers (a population to practitioner ratio of 10,000:1)."

See <http://bhpr.hrsa.gov/shortage/index.htm>.

## Shortage of Qualified Physicians

The Association of American Medical Colleges projects that there will be a shortage of as many as 124,000 full-time physicians by 2025.<sup>8</sup> This shortage is expected to hit the specialties of family medicine and internal medicine especially hard, as the number of U.S. medical graduates entering residencies in those areas of practice declined by half in the last decade.<sup>9</sup> This shortage of physicians will only increase if reforms proposed by President Barack Obama to provide healthcare for the forty-five million uninsured Americans are passed.<sup>10</sup>

Community hospitals in rural areas struggle constantly to find and recruit qualified physicians. While roughly 20% of the U.S. population lives in rural America, only 11% of physicians practice in those geographic areas.<sup>11</sup> According to the Institute of Medicine, it would take 16,261 additional primary care physicians to adequately serve patients residing in underserved areas.<sup>12</sup> In Alabama, the shortage of physicians has reached the point that sixty of sixty-seven counties have been designated HPSAs.<sup>13</sup> As an example, the medical staff development plan for a 115-bed community hospital in rural Alabama shows a need for twenty-five new physicians in five years, with six family practitioners needed immediately.

This lack of physicians, especially primary care, has a significant impact on community hospitals, which rely heavily on those physicians to provide basic, non-emergent services to patients within the hospital's service area. Without

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<sup>8</sup> *The Complexities of Physician Supply and Demand: Projections Through 2025*, Association of American Medical Colleges, available at [www.tht.org/education/resources/AAMC.pdf](http://www.tht.org/education/resources/AAMC.pdf).

<sup>9</sup> See *Bolster Primary Care: Avert a Physician Shortage*, January 5, 2009, [www.Amednews.com](http://www.Amednews.com), available at [www.ama-assn.org/amednews/2009/01/05/edsa0105.htm](http://www.ama-assn.org/amednews/2009/01/05/edsa0105.htm). In an attempt to promote primary care, the proposed 2010 Medicare Physician Fee Schedule, 74 Fed. Reg. 33519 (July 13, 2009), provides for an 8% increase in Medicare-allowed charges for family physicians.

<sup>10</sup> See Jacob Goldstein, *Canadians Worry U.S. Health Reform Could Lead to Doctor Poaching*, Washington Times, January 5, 2009.

<sup>11</sup> See *Rural and Urban Health*, Center on an Aging Society, Georgetown University, available at <http://hpi.georgetown.edu/agingsociety/pubhtml/rural/rural.html>.

<sup>12</sup> See *Statement for the Record, Hearing before the House Energy & Commerce Health Subcommittee, Making Health Care Work for American Families: Improving Access to Care*, American College of Physicians, March 24, 2009.

<sup>13</sup> See Ann DeBellis, *A Physician Shortage—Reversing the Trend*, Birmingham Medical News, July 2008.

these physicians, more patients use the emergency department for primary care treatment, which results in increased costs to the hospital, further reducing already-diminishing margins of return.

### **Physician Recruitment Strategies**

This section discusses the most common physician recruitment options (but not every option) available to community hospitals.

#### *Employment of Physicians*

While hospital employment of physicians is cyclical in nature (and until recently was out of favor), it appears that community hospitals are more willing to employ physicians to address physicians' expectations and concerns over compensation and increasing anxiety over the costs of private practice.<sup>14</sup> Often times, physicians who are willing to move to a rural area will do so only by joining an existing medical practice or becoming an employee of a facility. For a community hospital, employment of a physician is a hedge against competition from other hospitals and from being subjected to the referral whims of physicians on staff. It also allows the community hospital to maintain certain service lines (e.g., obstetrics, orthopedics, etc.) and sufficient on-call coverage.<sup>15</sup>

Historically, however, community hospitals have lost money on physician employment arrangements by guaranteeing high salaries without any corresponding incentive on the physician to maintain certain productivity levels. To address this concern, community hospitals are moving away from long-term, fixed salaries and are utilizing a variety of compensation models based on a physician's personal productivity. When possible, lower base salaries with

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<sup>14</sup> In a 2005 survey by the National Association of Physician Recruiters, 66% of its members said they have noticed a boost in hospitals employing physicians. Rick Johnson, *Dr. Punch Clock*, Health Leaders Magazine, May 2006. Contributing to the compensation concerns are the increased debt load of recent medical school graduates, which is on average between \$150,000 and \$200,000. Richard Scheffler, *Recruiting the docs we need*, Modern Healthcare, January 26, 2009. Recent changes to the Stark Law and new Medicare Anti-markup provisions which make it more difficult for physicians to generate revenue through ancillary services also serve to increase the attractiveness of hospital employment.

<sup>15</sup> For a discussion of issues associated with hospital employment of physicians, See Matthew Albers, *Physician-Hospital Integration as a Business Model*, Business Law Update, published by the AHLA Business Law and Governance Practice Group, October 20, 2009.

bonuses based on collections are employed, often in a tiered approach that quickly (e.g., after one to two years) moves the physician compensation from a guaranteed salary to production based. For some specialties, such as obstetrics and family practice, and in markets with high uninsured or underinsured populations, community hospitals are utilizing compensation models based on Work Relative Value Units (WRVUs) that compensate physicians based on the amount of work performed, rather than collections. Benchmarks based on productivity, cost savings, patient satisfaction, and coding and medical record efficiencies are also utilized in compensation models.

From a compliance standpoint, commercially reasonable and fair market value compensation paid by a community hospital to a physician who is a *bona fide* employee should satisfy the Stark Law, Anti-Kickback Statute and, if applicable, tax-exempt requirements.<sup>16</sup> The key element is fair market value compensation, and many hospitals use national compensation surveys such as the one published annually by the Medical Group Management Association to verify the appropriateness of compensation amounts. Bonuses based on personal productivity are permissible, while payments based on the value or volume of physician referrals or the sharing of a hospital department's net revenue are typically prohibited.<sup>17</sup> All employment arrangements should be carefully documented in writing and periodically reviewed to verify continued compliance

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<sup>16</sup> See Stark Law "Bona fide Employment Relationships" Exception at 42 C.F.R. § 411.357(c); Anti-Kickback Statute "Employees" Safe Harbor at 42 C.F.R. § 1001.952(i). It is also important to determine whether there are any analogous state laws that impact the employment arrangement.

<sup>17</sup> Over the past few years, the U.S. Department of Health and Human Services, Office of Inspector General (HHS OIG) has approved through its Advisory Opinion process several physician-hospital "gainsharing" arrangements. These arrangements allow physicians to work jointly with hospitals in order to improve patient care in a particular hospital department and lower costs and expenses. The physicians receive economic incentives to achieve certain cost-savings while maintaining quality medical care. See OIG Advisory Opinions 08-21 and 09-06, available at <http://oig.hhs.gov/fraud/advisoryopinions/opinions.asp>.

As required by Section 5007 of the Deficit Reduction Act of 2005, the Centers for Medicare and Medicaid Services (CMS) has also initiated gainsharing demonstration projects to test and evaluate methodologies and arrangements between hospitals and physicians "to improve the quality and efficiency of care provided to beneficiaries and to develop improved operational and financial hospital performance with sharing of gains." [www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/DRA5007\\_Solicitation.pdf](http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/DRA5007_Solicitation.pdf). As part of the program, this year CMS selected twelve New Jersey hospitals and their physicians for a three-year trial. See *CMS Approves New Jersey Gainsharing Demonstration Project*, HealthCare Finance News, at [www.healthcarefinancenews.com/news/cms-approves-new-jersey-gainsharing-demonstration-project](http://www.healthcarefinancenews.com/news/cms-approves-new-jersey-gainsharing-demonstration-project).

with regulatory requirements. Verifying fair market value compensation becomes particularly important if bonuses based on production are paid without a "cap," based on national compensation surveys.

### *Financial Assistance*

Apart from employment, a community hospital can offer a variety of financial incentives to a physician to encourage them to relocate to the hospital's service area and join the hospital's medical staff, including net income guaranties, net collection guaranties, forgivable loans, and financial assistance with advertising, malpractice costs, and moving expenses. For all hospitals, structuring a recruitment arrangement requires compliance with the Stark Law Physician Recruitment Exception and, if possible, the Anti-Kickback Statute Practitioner Recruitment Safe Harbor. Recruitment arrangements must also take into account whether the physician recruit is establishing their own medical practice or joining a medical practice already in the hospital's service area. Nonprofit entities have to be mindful of private inurement and other tax-exempt requirements.

In general, recruiting assistance is dependent on the community hospital satisfying the following requirements of the Stark Law Physician Recruitment Exception:<sup>18</sup>

1. Any financial assistance must be paid directly to the physician recruit;
2. The physician must relocate his/her medical practice<sup>19</sup> into the "geographic service area" served by the hospital in order to become a member of the

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<sup>18</sup> 42 C.F.R. § 411.357(e).

<sup>19</sup> A physician will be considered to have relocated his/her medical practice if the medical practice was located outside of the recruiting hospital's geographic service area and: (1) the physician moves his/her medical practice at least twenty-five miles and into the hospital's geographic service area, or (2) the physician moves his/her medical practice into the hospital's geographic service area and the physician's new medical practice derives at least 75% of its revenue from professional services furnished to patients (including hospital inpatients) not seen or treated by the physician at his/her prior medical practice site during the preceding three years, measured on an annual basis. For the initial "start up" year, the 75% test is satisfied if there is a "reasonable expectation" of compliance. The relocation requirements do not apply if the recruited physician is a resident or has been in practice one year or less. The requirements also do not apply if the physician was previously employed on a full-time basis for at least two years immediately prior to the recruitment in a federal or state prison, by the Department of Defense or Department of

hospital's medical staff. The geographic area served by the hospital is generally the area composed of the lowest number of contiguous zip codes from which the hospital draws at least 75% of its inpatients;<sup>20</sup>

3. The arrangement must be in writing and signed by the physician and hospital;

4. The amount of financial assistance is not conditioned on the physician's referral of patients to the recruiting hospital, and the physician is free to establish staff privileges at other facilities and to refer business to any other entity (except if referrals are restricted under an employment agreement);<sup>21</sup> and

5. The amount of financial assistance is not determined (directly or indirectly) on the volume or value of any actual or anticipated referrals from the recruited physician or other business generated between the parties.

If the physician is recruited to join an existing medical practice, the financial assistance must remain with the physician except for actual recruiting costs incurred by the medical practice. Additionally, under a net income guarantee arrangement, the medical practice can offset against the guarantee an amount not to exceed the practice's actual additional incremental costs attributable to the recruited physician.<sup>22</sup>

Community hospitals, if located in a rural area, have added flexibility when it comes to structuring recruitment arrangements. For such facilities, the "geographic area served by the hospital" can be expanded to the lowest number of contiguous zip codes from which the hospital draws at least 90% (rather than

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Veterans Affairs, or in a facility of the Indian Health Service, and did not otherwise maintain a private practice. 42 C.F.R. § 411.357(e)(2)(iv), (3).

<sup>20</sup> With respect to a hospital that draws fewer than 75% of its inpatients from all of the contiguous zip codes from which it draws inpatients, the geographic area served by the hospital will be deemed to be the area composed of all of the contiguous zip codes from which the hospital draws its inpatients. 42 C.F.R. § 411.357(2)(ii).

<sup>21</sup> This requirement can be particularly troubling for community hospitals that have limited resources to recruit, yet can find themselves providing support for a physician who practices at a competing hospital located within the same city or county. To address this concern, a community hospital can require the recruited physician to maintain their full-time medical practice in a location in close proximity to the recruiting hospital, thereby making it less convenient, although not prohibitive for the physician to refer to a competing facility.

<sup>22</sup> 42 C.F.R. § 411.357(e)(4).

75% ) of its inpatients.<sup>23</sup> If the hospital draws fewer than 90% of its inpatients from all of the contiguous zip codes from which it draws inpatients, its geographic service area may include noncontiguous zip codes, beginning with the noncontiguous zip code in which the highest percentage of the hospital's inpatients reside.<sup>24</sup> This provision allows rural community hospitals a larger geographic area within which the recruited physician can relocate (although the greater the distance from the recruiting hospital, the greater the concern that referrals will not go to the hospital).

The Stark Law exception also provides community hospitals additional flexibility if a physician is recruited to join an existing medical practice located in a rural area or HPSA.<sup>25</sup> If the physician is recruited to replace a physician who, within the previous twelve-month period, retired, relocated outside of the hospital's geographic service area, or died, the costs allocated by the medical practice to the recruited physician under a net income guarantee can be the greater of either: (1) the actual additional incremental costs attributable to the recruited physician, or (2) the lower of a *per capita* allocation among the medical practice physicians or 20% of the practice's aggregate costs. Since placement of a recruited physician in an existing medical practice is often preferred over the physician beginning his/her practice as a sole practitioner, some community hospitals have additional flexibility to structure a net income guarantee to provide financial assistance in an amount in excess of the medical practice's actual additional incremental costs incurred with respect to the recruited physician. This provision can prove helpful if the medical practice is concerned that its new additional incremental costs will be minimal, and it wants to allocate additional existing overhead (e.g., staff, personnel, equipment costs, etc.) to the recruited physician for purposes of a net income guarantee.

The Anti-Kickback Statute Practitioner Recruitment Safe Harbor sets forth additional requirements for the recruitment of physicians by hospitals, including

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<sup>23</sup> 42 C.F.R. § 411.357(e)(2)(iii).

<sup>24</sup> *Id.*

<sup>25</sup> 42 C.F.R. § 411.357(4)(iii).

that at least 75% of the revenues generated by the recruited physician in their new practice must be from new patients not previously seen by the physician at their former practice and that at least 75% of the revenues of the new practice must be generated from patients residing in a HPSA or MUA or who are part of a MUP. Further, any financial assistance is limited to a three-year period.<sup>26</sup> For physicians with existing practices relocating into a community hospital's service area, this safe harbor is only available for primary care physicians. For this reason and because of the 75% requirements set forth above, many recruitment arrangements do not qualify for safe harbor protection. However, the fact that a particular arrangement does not fall within a safe harbor does not mean that the arrangement violates the Anti-Kickback Statute. Rather, the safe harbor regulations provide assurances that qualifying arrangements will not be viewed as violating the Anti-Kickback Statute. Thus, arrangements that do not qualify for safe harbor protection are not illegal per se, but must be carefully evaluated in light of the provisions of the Anti-Kickback Statute and should be structured to meet as many of the substantive requirements of an applicable safe harbor as possible. It is important to note, that satisfying the Stark Law Physician Recruitment Exception does not guarantee that the arrangement will pass scrutiny under the Anti-Kickback Statute.

### *J-1 Visa Physicians*

If a community hospital is located in a HPSA or MUA, it is eligible to recruit a foreign medical graduate, often referred to as a J-1 Visa "Waiver" physician. Under the J-1 Visa Program, a foreign medical graduate can pursue graduate training in the United States typically for up to seven years. In accordance with Section 212(e) of the Immigration and Nationality Act, as amended, all J-1 Visa physicians are obligated upon completion of their training to return to their home country for at least two years or obtain a "J-1 Visa Waiver." The waiver allows a physician to stay in the United States if the physician agrees to work in a HPSA

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<sup>26</sup> 42 C.F.R. § 1001.952(n).

or MUA and is sponsored by an Interested Government Agency (IGA)<sup>27</sup> or state health department. At present, each state can issue up to thirty waivers in a federal fiscal year.<sup>28</sup> While the exact waiver requirements vary between each state, to obtain a waiver from a state Department of Health a physician must have a full-time offer of employment (forty hours per week) from a facility in a HPSA or MUA, a letter of support from the applicable state agency responsible for implementing the waiver program, a three-year employment contract and, in certain situations, a "no-objection" letter from the physician's home country. After the three-year obligation, the physician may apply for permanent residence visa status.

### **Physician Retention Strategies**

For the most part, hospitals are prevented from offering any type of financial assistance or support to a physician once they establish a medical practice in the hospital's service area and join the hospital's medical staff. There are, however, several unique retention "tools" available to community hospitals located in rural areas, MUAs, or HPSAs that are not generally available to hospitals located in metropolitan areas.

#### *Obstetrical Malpractice Insurance Assistance*

In recognition of the significant need for retaining obstetricians, a Stark Law exception allows a hospital to pay some or all of the malpractice insurance costs for an obstetrician on staff.<sup>29</sup> While the exception has several requirements, as a threshold condition the physician's medical practice must be located in a rural area, a primary care HPSA, or an "area of need" determined by the HHS

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<sup>27</sup> While any government agency can act as an IGA, most of the time the Department of Veterans Affairs, HHS, Appalachian Regional Commission, and the United States Department of Agriculture serve as IGAs. See Karma Ester, *Foreign Medical Graduates: A Brief Overview of the J-1 Waiver Program*, CRS Report for Congress, January 26, 2007.

<sup>28</sup> The ability of states to request a waiver is also known as the Conrad state-based waiver program after Senator Kent Conrad (D-ND).

<sup>29</sup> 42 C.F.R. § 411.357(r). Federally qualified health centers and rural health clinics can also take advantage of this Stark Law exception.

Secretary through an Advisory Opinion.<sup>30</sup> In the alternative, at least 75% of the physician's obstetrical patients must reside in a MUA or qualify as members of a MUP. Further, at least 75% of the physician's obstetrical patients during the assistance period: (1) reside in a rural area, HPSA, MUA, or an area of need determined by the HHS Secretary through an Advisory Opinion, or (2) were part of a MUP. In certain circumstances, assistance is also available for physicians who engage in obstetrics on a part-time or sporadic basis. However, for those physicians the community hospital can only pay the costs attributable to the obstetrical portion of the physician's malpractice insurance. The Anti-Kickback Statute, at 42 C.F.R. § 1001.952(o), contains a safe harbor addressing the payment of obstetrical malpractice insurance which contains similar but not identical requirements. If an arrangement satisfies the Anti-Kickback Safe Harbor for obstetrical insurance subsidies, it is deemed Stark Law compliant.<sup>31</sup>

#### *Physician Retention Payments*

Many community hospitals find that once a physician is recruited to the hospital's service area, retention of the physician becomes an even more difficult task. Physicians often want to stay in the community, but face economic pressures to relocate to a more urban and often larger medical practice setting. If a physician has a *bona fide* written recruitment offer or offer of employment<sup>32</sup> to move his/her practice at least twenty-five miles and outside of a community hospital's

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<sup>30</sup> Congress established the OIG Advisory Opinion process as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The process allows individuals or entities to request formal written guidance on whether particular arrangements comply with the Anti-kickback Statute, the Anti-kickback "Safe Harbor" regulations, as well as the exclusion authorities in section 1128 of the Social Security Act, and the Civil Monetary Penalty authorities in section 1128A of the Social Security Act. The OIG will not issue an Advisory Opinion on hypothetical situations, Stark Law, or on the fair market value of goods, services, or property. To request an Advisory Opinion, one must submit a written request that contains specified information as outlined by the OIG. Advisory Opinions are made available to the public through the OIG's website, although identifying information such as the names of the parties, are removed before posting. However, detailed information submitted in connection with an Advisory Opinion request may be subject to disclosure under the Freedom of Information Act. See OIG website, <http://oig.hhs.gov/fraud/advisoryopinions.asp>.

<sup>31</sup> 42 C.F.R. § 411.357(r)(1).

<sup>32</sup> 42 C.F.R. § 411.357(t). If a physician does not have a *bona fide* written offer of employment, the community hospital and physician may still satisfy the requirement via written certification by the physician of a *bona fide* opportunity for future employment and that such opportunity meets the requirements of the Stark Law. See 72 Fed. Reg. at 51066 (Sep. 5, 2007).

geographic service area, the Stark Law allows the community hospital to offer certain retention payments; provided, however, that the physician's current practice is located in a rural area or HPSA (regardless of the physician's specialty) or is located in an area of need determined by the HHS Secretary through an Advisory Opinion.<sup>33</sup> In the alternative, at least 75% of the physician's patients must reside in a MUA or qualify as members of a MUP. The amount of any retention payment is limited by the Stark Law exception and cannot be provided to a physician more frequently than once every five years.<sup>34</sup>

### *Physician-Hospital Joint Ventures*

Community hospitals located in rural areas have the option of being able to joint venture with physicians to provide designated health services covered by the Stark Law, such as clinical laboratory services, physical or occupational therapy, diagnostic imaging, or radiation therapy services. To satisfy the Stark Law Rural Provider Exception,<sup>35</sup> the joint venture entity must be located in a rural area and must furnish "substantially all" of its designated health services to individuals residing in a rural area. 42 C.F.R. §411.356(c) clarifies that "substantially all" requires that at least 75% of the entity's designated health services must be furnished to individuals residing in a rural area.

The Anti-Kickback Statute also provides a safe harbor for physician-hospital joint ventures located in a MUA, which typically overlaps with a rural area designation. The Underserved Area Investment Safe Harbor<sup>36</sup> provides that prohibited "remuneration" for purposes of the Anti-Kickback Statute does not include any payment that is a return on an investment interest made to a physician investor, so long as several elements are satisfied, including: (1) the entity in which the investment is held is located in a MUA; (2) at all times during either the entity's most recent fiscal year or the last twelve months, no more than 50% of the entity was owned by investors who are in a position to make or influence referrals to,

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<sup>33</sup> *Id.* Federally qualified health centers and rural health clinics can also take advantage of this Stark Law exception.

<sup>34</sup> There is no corresponding Anti-Kickback Statute Safe Harbor.

<sup>35</sup> 42 C.F.R. § 411.356(c)(1).

<sup>36</sup> 42 C.F.R. § 1001.952(a)(3).

furnish items or services to, or otherwise generate business for the entity<sup>37</sup>; (3) the terms on which the opportunity to invest is offered to a physician investor is not related to the previous or expected volume of referrals, items or services furnished, or business generated from the investor to the entity; (4) at least 75% of the dollar volume of the entity's business in the previous fiscal year or previous twelve-month period is generated from the services of patients who reside in a MUA or are members of a MUP; (5) the funds used to purchase the investment by physician investors who are in a position to refer patients, furnish items or services, or generate business were not lent or guaranteed by the joint venture entity; and (6) the return on investment is directly proportional to the amount of the investment (including the fair market value of any preoperational services rendered), rather than, for example, being based on the volume or value of referrals. The use of this safe harbor can prove particularly helpful to community hospitals that want to align their interests more closely with medical staff physicians. The opportunity to participate in a joint venture arrangement can also be used by a community hospital as a recruitment and retention tool.

## **Conclusion**

The recruitment and retention of physicians will continue to present a significant challenge for community hospitals. The diminishing number of qualified physician recruits coupled with the current economic crisis and decreasing hospital reimbursement will require community hospitals to take advantage of every legal recruiting and retention option available. Accordingly, community hospitals should develop a well-thought-out physician recruiting and retention plan that allows the hospital to quickly present to prospective physicians creative financial options otherwise not available from urban competitors.

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<sup>37</sup> OIG Guidance indicates that a hospital, through employed practitioners, medical staff members, and independent contractor practitioners, will be viewed as being in a position to make or influence referrals to the joint venture entity and will be counted toward the 50% limitation. However, the OIG has issued several Advisory Opinions that approve physician-hospital joint ventures where the hospital's participation results in ownership by referring investors beyond the 50% Underserved Area Investment Safe Harbor requirement. See OIG Advisory Opinions, 97-5, 03-12, and 03-13, available at <http://oig.hhs.gov/fraud/advisoryopinions/opinions.asp>.

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