Annual Survey of Virginia Law: Health Care Law

Steven D. Gravely

Follow this and additional works at: http://scholarship.richmond.edu/lawreview

Part of the Health Law and Policy Commons

Recommended Citation
Available at: http://scholarship.richmond.edu/lawreview/vol26/iss4/14

This Article is brought to you for free and open access by the Law School Journals at UR Scholarship Repository. It has been accepted for inclusion in University of Richmond Law Review by an authorized editor of UR Scholarship Repository. For more information, please contact scholarshiprepository@richmond.edu.
I. Overview and Introduction

The health care industry continued its dynamic course in late 1991 and early 1992. Feeding the frenzy of activity were the Virginia General Assembly and the judiciary. This article focuses on key legislative, regulatory, and judicial events of the past year, and examines their effect on health care in Virginia.

II. Certificate of Public Need

The General Assembly substantially amended the Virginia Certificate of Public Need (COPN) statute during the 1992 Session. These amendments reimpose the requirement of COPN review on

---

* Shareholder and Director, Mezzullo & McCandlish, P.C., Richmond, Virginia; B.A., 1977, College of William and Mary; M.H.A., 1980, Medical College of Virginia, Virginia Commonwealth University; J.D., 1983, T.C. Williams School of Law, University of Richmond. Mr. Gravely concentrates his practice on the representation of health care clients, specifically hospitals, long term care facilities, physicians and other health care providers. The author gratefully acknowledges the assistance of Lisa R. Foeman, University of Virginia Law School, Class of 1994, in the research and preparation of initial drafts of portions of this article.

1. The Certificate of Public Need (COPN) statute, now codified at Va. Code Ann. §§ 32.1-102.1 to -102.11 (Repl. Vol. 1992), was initially passed in 1982. Act of Apr. 10, 1982, ch. 388, 1982 Va. Acts 634. The COPN program creates a regulatory framework through which the State Health Commissioner determines the public need for a proposed health care service. Under the terms of the statute, any individual or entity proposing any "medical care facility project," as defined in the statute, must obtain administrative agency approval. Current regulations require applicants to submit an extensive application which describes in detail all aspects of the proposed project including: ownership; type of project; space plans and drawings; staffing; capital expenditures; method of financing; and the need for the proposed expenditure. The Department of Health is permitted to require additional information before accepting a project for review. See 8:23 Va. Regs. Reg. 4203 (Aug. 10, 1992). The application undergoes an extensive review process which consists of a public hearing, review by regional health planning agencies, review by the Commissioner's staff and, usually, an evidentiary hearing. Id. at 4207-08. The Commissioner's decision on an application is a "case decision" entitling an aggrieved applicant to judicial review. Id. at 4210; see Va. Code Ann. § 32.1-102.6 (Repl. Vol. 1992); Va. Sup. Ct. R. 2A:2.
many activities which had been deregulated and also require review for the first time for a variety of undertakings by physicians.\textsuperscript{2}

COPN review for most capital expenditures, except those associated with the establishment of a new medical care facility or the addition of beds, and for the establishment of all except certain specific enumerated services, was eliminated by the General Assembly during its 1989 Session.\textsuperscript{3} To proponents of the 1992 COPN initiative, increased costs to the Commonwealth and the public from the alleged proliferation of medical care technology and the expansion of existing medical care facilities that had occurred since the “deregulation” of capital projects in 1989 justified reimposing COPN review. By significantly expanding the definition of a reviewable “project” and thereby increasing the number of activities requiring COPN review, the General Assembly has changed the focus in Virginia from one of deregulation to one of regulation for capital expenditures and new services by medical care providers.

A reviewable “project” now includes the initiation of a variety of health services, the addition of operating rooms, the acquisition or replacement of a broad range of diagnostic technology such as CT and MRI scanners, and any capital expenditure in excess of $1,000,000 which is made “by or in behalf of” a medical care facility, as well as the establishment of a medical care facility or the addition of beds which have always required a COPN.\textsuperscript{4}


\textsuperscript{4} VA. CODE ANN. § 32.1-102.1 (Repl. Vol. 1992). “Project” is defined as:
1. Establishment of a medical care facility;
2. An increase in the total number of beds or operating rooms in an existing medical care facility;
3. Relocation at the same site of ten beds or ten percent of the beds, whichever is less, from one existing physical facility to another in any two-year period; however, a hospital shall not be required to obtain a certificate for the use of ten percent of its beds as nursing home beds as provided in § 32.1-132;
4. Introduction into an existing medical care facility of any new nursing home service, such as intermediate care facility services, extended care facility services, or skilled nursing facility services, regardless of the type of medical care facility in which those services are provided;
5. Introduction into an existing medical care facility of any new cardiac catheterization, computed tomographic (CT), gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), medical rehabilitation, neonatal special care, obstetrical, open heart surgery, positron emission tomographic (PET) scanning, psychiatr[ic]c, organ or tissue transplant service, radiation therapy, single photon emission computed tomography (SPECT), substance abuse treatment,
Whether a particular expenditure is made "in behalf of" a medical care facility will depend upon the specific facts of each case. Correspondence and decisions by the Department of Health since passage of the 1992 COPN amendments indicate that almost all expenditures involving a medical care facility in any way will be deemed to be an expenditure "on behalf of" the medical care facility. The Department has ruled that construction of a medical office building by a private developer on a hospital campus is an expenditure "in behalf of" the hospital due to the use of hospital property and the fact that the hospital planned to lease space in the building. The Department has opined that the "type and location of [a] project and the nature of the legal entity [involved] are the key considerations."

The determination of whether a particular expenditure is being made "by or in behalf of" a medical care facility will likely generate considerable controversy. Preliminary indications are that the Department of Health, not surprisingly, is taking an expansive view of the statutory language. Whether this view is consistent with the "plain meaning" of the statute remains to be seen.

The 1992 amendments to the COPN statute also expanded the definition of a "medical care facility" to include any portion of a

or such other specialty clinical services as may be designated by the Board by regulation, which the facility has never provided or has not provided in the previous twelve months;
6. The addition or replacement by an existing medical care facility of any medical equipment for the provision of cardiac catheterization, computed tomographic (CT), gamma knife surgery, lithotripsy, magnetic resonance imaging (MRI), magnetic source imaging (MSI), open heart surgery, positron emission tomographic (PET) scanning, radiation therapy, single photon emission computed tomography (SPECT), or other specialized service designated by the Board by regulation; notwithstanding the above, the Commissioner shall develop regulations providing for the replacement by a medical care facility of existing medical equipment, which is determined by the Commissioner to be inoperable or otherwise in need of replacement without requiring issuance of a certificate of public need; or
7. Any capital expenditure of one million dollars or more, not defined as reviewable in subdivisions 1 through 6 of this definition, by or in behalf of a medical care facility.
Id.
5. See, e.g., Correspondence from Paul E. Parker, Director, Division of Resources Development, Virginia Department of Health, to Thomas W. McCandlish, Mezzullo & McCandlish, P.C. (July 8, 1992). While the Parker correspondence uses the term "on behalf of," there seems to be no practical difference from the statute's use of "in behalf of."
7. Parker Correspondence, supra note 5, at 1.
8. See supra notes 6-7 and accompanying text.
physician's office involved in the provision of services which would otherwise now constitute a "project" under the expanded definition of that term. This means that, for the first time in Virginia, the activities of physicians in their private offices may be subject to COPN review by the State Health Commissioner. Some observers see this as an attempt to "level the playing field" so that physicians are subject to the same regulatory requirements as hospitals when they undertake similar activities. The General Assembly also extended the moratorium on nursing home COPNs through June 30, 1994. The exemptions to the moratorium remain in effect.

These amendments took effect on July 1, 1992. The statute does provide for exemptions from the new requirements in specific circumstances. However, applications for exemption were required to be filed by August 1, 1992. Those who applied for an exemption on or before August 1, 1992 are entitled to administrative review in accordance with the provisions of the Virginia Administrative Process Act. Denial of a request for exemption is an appealable case decision in accordance with the APA.

Subsequent to enactment of the COPN statute amendments, the Department of Health undertook a comprehensive revision of the Virginia State Medical Facilities Plan (SMFP). The SMFP had been last updated in 1988. The revised SMFP, which took effect on July 10, 1992, adopts more detailed and more stringent standards for approval of COPN applications. Those standards discuss not only criteria for demonstrating need but also criteria for accessibility, cost, and quality. Compliance with the SMFP is a prerequisite to appeal of a COPN application pursuant to Virginia Code section 32.1-102.3.

11. Id.
12. Id. § 32.1-102.11(A).
13. Id. § 32.1-102.11(B).
16. 8:23 Va. Regs. Reg. 4212-13 (Aug. 10, 1992). Due to the length of the regulation, the Virginia Register contains a summary of the State Medical Facilities Plan in lieu of the full text.
17. Id. at 4213.
18. The Code allows the State Health Commissioner to set aside the SMFP in certain cases. Va. Code Ann. § 32.1-102.5(A) (Repl Vol 1992). While the Commissioner has set aside the 1988 SMFP in recent years, this is much less likely now that a new SMFP has been adopted.
To implement the changes to the COPN statute, the Department of Health promulgated revisions to the Rules and Regulations Governing the Certificate of Public Need Program (Rules & Regulations) effective July 10, 1992. The revised regulations significantly modify some aspects of the application review processes. In contrast to the previous rules, which merely required an applicant to file a request for forms before submitting an application, the current rules require applicants to file a letter of intent regarding a planned COPN application at least thirty (30) days prior to submission of an application. Like the previous rules, the letter of intent must identify the owner, the type of project, and the proposed scope and location of the project.

The revised COPN regulations also adopt a "batching" process for reviewing COPN applications. Under this process, COPN applications for specific health services are grouped together in a "batched" review cycle. There are only two review cycles each year for batch groups A-F. Nursing home projects, for which a COPN moratorium remains in effect, will be reviewed by planning district with only one review cycle per year for each district. This change in the regulations represents a dramatic shift from the previous rules which reviewed any proposed project for a particular service on the tenth day of each month, provided the application was complete. Unlike the prior rule, the new regulation affords the Commissioner the opportunity to evaluate all applicants for a particular service at one time, thereby increasing the Commissioner's ability to assess public need and to perform a more informed cost/benefit analysis.

While the proposed batching regulation may promote more effective comparative review of similar applications, it poses special problems for applicants. By providing for separate review of every aspect of a project, the rule may cause added expense and delay by

22. Id. at 4202-08.
23. Id. at 4203. The seven "batch of groups" are set forth at 8:23 Va. Regs. Reg. 4203-06.
impeding an applicant's ability to wholly plan a project in advance or by necessitating piecemeal construction of projects.

Another significant change in the revised COPN regulations is a new section entitled “Requests for Applications.” This provision gives the Commissioner authority to request applications for identified specific needs for services and facilities. On a practical level, this provision demonstrates the Commonwealth's renewed activist role in the health care arena. This provision could be promising since it would create incentives for developers to supply services or build facilities in underserved areas of the state.

The new Rules and Regulations eliminate the reporting and registration requirements for covered projects and place requests for emergency replacement of medical equipment outside the definition of “project.” For the latter, a certificate of need will not be required. In addition, standards for determining “emergency replacement” are set out in the new rules.

The general trend in COPN law is the use of increased regulation as a mechanism to enhance competition in health care. Regulators hope that more competition will lead to decreased costs, higher quality of service, and improved accessibility to the system. Examination of the Virginia health care system over the next several years will be crucial in determining whether these changes actually bring about the desired results.

III. THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (COBRA)

The Emergency Medical Treatment & Active Labor Act was enacted by Congress in 1986, as part of the 1986 Consolidated Omnibus Budget Reconciliation Act (COBRA), in response to a perception that indigent persons with emergency medical conditions were being denied access to appropriate medical care. The pertinent provisions of COBRA assure access to hospital care for persons who require emergency care or women in active labor.

26. Id. at 4200-01.
27. Id. at 4201-02.
28. Id.
29. Id.
31. Id.
BRA applies to hospitals, and perhaps physicians, in the Commonwealth by virtue of their participation in the Medicare and Medicaid Program.\textsuperscript{32}

There have been several recent decisions by federal and state courts in Virginia construing the duty imposed on hospitals by COBRA. The trend in these cases is to expand the ability of plaintiffs to recover damages under COBRA for adverse medical outcomes.

The COBRA provisions attempt to eliminate alleged “patient dumping”\textsuperscript{33} through three basic provisions. The first provision requires a hospital which has an emergency department and which participates in the Medicare program to perform, within its capability, a medical screening examination on any individual who comes to the emergency room requesting treatment.\textsuperscript{34} Second, if a hospital determines that a hospital patient has an emergency condition or is in active labor,\textsuperscript{35} the hospital must either stabilize\textsuperscript{36} the patient or transfer\textsuperscript{37} the individual to another medical facility.\textsuperscript{38}

\textsuperscript{32} COBRA first became effective August 1, 1986, and was enacted to prevent hospitals from refusing treatment to or transferring indigent patients with emergency medical conditions, a practice commonly referred to as “patient dumping.” Congress sought to eliminate patient dumping by requiring that any hospital receiving federal funds accept any individual seeking treatment in its emergency room. By law, if the hospital refused, it would risk the loss of funding. See, e.g., Smith v. Richmond Memorial Hosp., 243 Va. 445, 449, 416 S.E.2d 689, 691 (1992).

\textsuperscript{33} The phrase “patient dumping” refers to the practice of a hospital transferring a patient, who has an emergency medical condition or who is in active labor, to another hospital rather than treating the patient. Id.

\textsuperscript{34} 42 U.S.C. § 1395dd(a) (Supp. II 1990).

\textsuperscript{35} Id. § 1395dd(e)(1). “Emergency medical condition” means (a) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (i) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part; or (b) with respect to a pregnant woman who is having contractions (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child. Id.

\textsuperscript{36} Id. § 1395dd(e)(3)(A). “To stabilize” means to provide medical treatment necessary to assure, within reasonable medical probability, that no material deterioration of the emergency medical condition or active labor is likely to result or occur during or from the transfer of the individual from a facility. Id.

\textsuperscript{37} Id. § 1395dd(e)(4). “Transfer” means “the movement (including the discharge) of an individual outside a hospital’s facilities at the direction of any person employed by (or affiliated or associated directly or indirectly with) the hospital, but does not include such a movement of an individual who (a) has been declared dead, or (b) leaves the facility without the permission of any such person. Id.

\textsuperscript{38} Id. § 1395dd(b). A hospital is deemed to satisfy these requirements if the hospital offers the individual further medical examination and treatment or offers to transfer the
nally, in the event that the individual is not stabilized, the hospital may not transfer that individual except in certain limited circumstances.\textsuperscript{39}

The COBRA provisions raise many troublesome issues. The statute is silent as to who exactly is responsible for medical screening and determining whether the individual has an emergency medical condition or is in active labor. Case law suggests that the physician designated as the "emergency room" physician or covering the obstetrical service at the time bears the ultimate responsibility. However, it is the hospital that is subject to damages and sanctions under COBRA. Similarly, the medical screening requirement presents special problems for hospitals and physicians treating managed care patients. Where the third-party payer has refused to authorize treatment and reimbursement for care provided, the hospital or physician, by law, still must determine whether the individual presenting to the emergency room has an emergency medical condition. If so, then the hospital is obligated to treat and either stabilize or transfer, if appropriate, the individual regardless of method of payment. Likewise, those hospitals that allow private physicians to come to the emergency room to treat their own patients should be wary of potential lawsuits if a medical screening is not conducted on a patient upon arrival. Moreover, the issue of to whom COBRA applies, whether all individuals or only the indigent/uninsured, remains unresolved.\textsuperscript{40}

In \textit{Smith v. Richmond Memorial Hospital},\textsuperscript{41} the Virginia Supreme Court was called upon to evaluate the application of COBRA to a hospital inpatient. Specifically, the issue on appeal related to whether the treatment and transfer provisions of COBRA are restricted to individuals admitted to an emergency room whose emergency medical condition or active labor had not been stabili-
lized, or whether the requirements also apply when an emergency medical condition or active labor occurred after admission to the hospital and initial stabilization of the patient's condition.\textsuperscript{42}

In \textit{Smith}, a woman, thirty-three weeks pregnant at the time, was admitted to Richmond Memorial Hospital on July 18, 1988, for premature rupture of the uterine membrane. She remained at the hospital until July 23, 1988. On July 22, the patient complained of abdominal cramping and vaginal leakage, and later in the day, contractions. That night, the patient was taken to the labor and delivery suite of the hospital. Still experiencing vaginal discharge complications, the patient was ordered transferred to The Medical College of Virginia Hospital (MCV) by a physician who had not examined her. After encountering difficulty obtaining an ambulance service, Richmond Memorial transferred appellant to MCV, where she gave birth to her daughter by cesarean section. Both mother and daughter suffered substantial injuries; the daughter has cerebral palsy and severe brain damage.\textsuperscript{43}

The mother sued Richmond Memorial in her individual capacity and on behalf of her daughter, alleging that her transfer from Richmond Memorial to MCV while in a medically-unstable condition constituted a violation of COBRA.\textsuperscript{44}

The hospital demurred on three grounds. First, the hospital argued that the claim was not actionable under COBRA since it was fundamentally a medical malpractice claim. Second, the hospital argued that since appellant did not allege that her indigent status motivated her transfer from Richmond Memorial to MCV, no actionable claim under COBRA was established. Finally, the hospital argued that no notice of claim was given as required by Virginia Code section 8.01-581.2.\textsuperscript{45}

The trial court concluded that section 8.01-581.2 did not apply to claims based on a COBRA violation.\textsuperscript{46} However, the trial court

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{42} Id. at 450, 416 S.E.2d at 691.
\item \textsuperscript{43} Id. at 447-48, 416 S.E.2d at 690.
\item \textsuperscript{44} Id. at 448, 416 S.E.2d at 690.
\item \textsuperscript{45} Id. Section 8.01-581.2 states in relevant part that "[n]o action may be brought for malpractice against a health care provider unless the claimant notifies the health care provider in writing by registered or certified mail prior to commencing the action. The written notification shall include the time of the alleged malpractice and a reasonable description of the act or acts of malpractice." \textit{Va. Code Ann. § 8.01-581.2} (Repl. Vol. 1992).
\item \textsuperscript{46} \textit{Smith}, 243 Va. at 448, 416 S.E.2d at 690. On appeal, the court reviewed the hospital's assignment of cross-error on the notice issue. The court disagreed with the hospital's assertion that the notice of claim provision did not conflict with COBRA since complying with
\end{itemize}
\end{footnotesize}
agreed that appellant’s claim was one for medical malpractice, not a COBRA violation. Consequently, the trial court held that no actionable claim under COBRA was pleaded since COBRA does not cover “emergency conditions arising from medical neglect during a stay in a hospital.”

On appeal, the hospital argued that appellant did not sufficiently plead a COBRA violation for two reasons. First, the hospital asserted “that coming to an emergency room in an emergency medical condition or in labor is a prerequisite to the application of the treatment and transfer provisions of subsections (b) and (c) of the Act. . . .” Since the appellant did not plead either of the prerequisites, the hospital argued that the claim should fail. Also, the hospital asserted that COBRA was inapplicable to the situation since the appellant acknowledged that her condition had been stabilized prior to the event causing the transfer. Second, the hospital argued that appellant’s claim was one for misdiagnosis or improper treatment, neither of which falls within the scope of COBRA.

The appellant responded that under the language of the Act, a patient may have a cause of action even if the patient is not transferred from an emergency room. Consequently, appellant argued that a hospital cannot avoid COBRA liability by “initially stabilizing a patient, allowing the patient to again become unstable and then transferring the patient.”

In resolving these issues, the supreme court declined to resort to rules of statutory construction, stating that the words of the statute were plain and unambiguous. Although acknowledging that a patient must be in an emergency medical condition or in active labor before subsections (a) and (b) will apply, the court went on

the Virginia statute’s notice provision could make an individual ineligible to file a claim within COBRA’s two-year statute of limitations period. Id. at 455, 416 S.E.2d at 695. The Virginia Code prohibits an individual from filing a medical malpractice claim against a provider until 90 days after notification. VA. CODE ANN. § 8.01-581.2(A) (Repl. Vol. 1992).

For a case concerning waiver of the notice provisions found in COBRA, see Layton v. Kroger Co., 924 F.2d 1052 (4th Cir. 1991).

47. Smith, 243 Va. at 448-49, 416 S.E.2d at 690-91.
48. Id. at 449-50, 416 S.E.2d at 691.
49. Id. at 450, 416 S.E.2d at 691.
50. Id.
51. Id. at 452, 416 S.E.2d at 692. The court declined to address the hospital’s second argument. The hospital admitted that a medical malpractice claim and COBRA claim could exist simultaneously. Finding that a COBRA claim had been pleaded, the court noted that whether the COBRA claim in reality was only a traditional malpractice claim is an issue of fact, not pleading, possibly subject to a motion for summary judgment. Id. at 455 n.3, 416 S.E.2d at 694 n.3.
to substantially broaden the reach of the statute. The court con-
cluded that the language of COBRA does not limit application of
subsections (b) and (c) only to individuals that initially arrive at
the emergency room and who have not been stabilized. On the
contrary, the court concluded that the Act extends beyond the
emergency room. Looking to the Act's purpose, prevention of pa-
tient dumping, the court agreed that patient dumping is not re-
stricted to a refusal to provide emergency room treatment.

The Virginia federal courts likewise have issued decisions inter-
preting the language of COBRA. In McIntyre v. Schick, the
plaintiff, who had no health insurance, allegedly came to Virginia
Beach General Hospital (VBGH) on November 1, 1989 at 7:15 p.m.
"with labor contractions, persistent sinusoidal fetal heart patterns
and lack of fetal beat-to-beat variability." Plaintiff remained at the
hospital for eleven hours and twenty-five minutes before being for-
mally admitted. The plaintiff contended that the hospital required
admission of patients after a twelve-hour stay, and that this policy
resulted in Mrs. McIntyre's negligent discharge on November 2,
1989, at 6:40 a.m. Later that night, plaintiff, allegedly suffering
from the same condition, returned to VBGH where Dr. Schick or-
dered her transferred to Norfolk General Hospital. There, she de-
levered an anemic baby boy by caesarian section. The infant died a
couple of days later.

Plaintiff's complaint alleged several violations of COBRA. First,
plaintiff alleged defendants Schick and VBGH violated COBRA by
discharging plaintiff before she was stabilized to avoid admitting
her to the hospital because she had no health insurance. Second,
plaintiff asserted that defendants violated COBRA when they

52. Id. at 454, 416 S.E.2d at 693-94.
55. Id. at *2-*3, 1992 WL 134713 at *1.
56. Id. at *5, 1992 WL 134713 at *2; see 42 U.S.C.A. §§ 1395dd(b), (c) (West 1992). Sub-
section (b) provides that when a hospital determines that an individual has an emergency
medical condition, the hospital must either stabilize the condition or transfer the individ-
ual to a medical facility with the resources to stabilize the condition. Subsection (c) provides
that a hospital may not transfer an individual with an unstabilized emergency medical condi-
tion unless (i) the individual makes an informed, written request for a transfer; (ii) a
physician certifies that the benefits of the transfer outweigh the risks; or (iii) another quali-
fied medical person signs such a certification and that person's signature is countersigned by
a consulting physician. Id.
transferred her to Norfolk General without obtaining the necessary signed certification of a physician. On a motion to dismiss this count for failure to state a claim, defendants contended that COBRA required plaintiff to plead that she came to the emergency department of the hospital.

Although agreeing that a plaintiff would have to seek care at a hospital’s emergency room in order to state a claim under subsection (a) of 42 U.S.C.A. § 1395dd, the court denied the motion to dismiss the count since plaintiffs pleaded their case under subsections (b) and (c) of that section. In reaching this conclusion, the court noted that the language of § 1395dd does not require every provision of the statute to be read in conjunction with subsection (a). The court reiterated that neither subsection (b) nor (c) refer back to subsection (a).

Like the Smith court, this court interpreted COBRA’s language broadly, concluding that COBRA does not apply solely to persons initially coming to the emergency room. Specifically, the court noted that “nowhere do subsections (b) and (c) state that an individual in an emergency medical condition or in active labor must enter through the emergency room.” Nor must an individual in another hospital department first be sent to the emergency room.

   
   [i]f an individual at a hospital has an emergency medical condition which has not been stabilized . . ., the hospital may not transfer the individual unless a physician . . . has signed a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer . . .

Id.

   
   In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual’s behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital’s emergency department . . . to determine whether or not an emergency medical condition . . . exists.

Id.


60. Id.

61. Id. at *10, 1992 WL 134713 at *2.
for an examination in order to state a claim under subsections (b) and (c).\textsuperscript{62}

In \textit{Petrovics v. Prince William Hospital Corp.},\textsuperscript{63} the court focused attention on the medical screening requirement of COBRA. In \textit{Petrovics}, the plaintiff came to the emergency room of Prince William Hospital on October 16, 1989, complaining of sharp pain between his shoulder blades. After an examination and administration of tests including chest x-rays, he was diagnosed as suffering from a recurrent back pain determined not to be an emergency condition. After plaintiff was discharged, the x-rays were sent to a radiologist for further review. The hospital, after being notified of an abnormality by the radiologist, called the plaintiff to return for further tests on October 19. Plaintiff did not return and on October 22 went to Fairfax Hospital where he was diagnosed as having pneumonia. Subsequently, plaintiff alleged that the hospital did not provide an adequate medical screening examination and failed to properly stabilize him before discharge as required by COBRA.\textsuperscript{64}

Evaluating plaintiff’s claim, the court found that Prince William Hospital did not violate its duties under the Act.\textsuperscript{65} The court noted that the Act requires hospitals to perform an appropriate medical screening.\textsuperscript{66} Citing a recent Sixth Circuit case,\textsuperscript{67} the court held that the hospital provided plaintiff an appropriate medical screening since it performed the same procedures on plaintiff as it would have on any other patient. Since an emergency condition was not detected, the hospital could not be responsible for failing to stabilize a known emergency condition.\textsuperscript{68}

The U.S. District Court for the Eastern District of Virginia, in a case decided on August 28, 1992,\textsuperscript{69} ruled that the Virginia limit of

\textsuperscript{62} Id.
\textsuperscript{64} Id. at 416.
\textsuperscript{65} Id. at 417.
\textsuperscript{66} \textit{See} 42 U.S.C. § 1395dd(a) (1988).
\textsuperscript{67} \textit{Cleland v. Bronson Health Care Group, Inc.}, 917 F.2d 266, 271 (6th Cir. 1990). In \textit{Cleland}, the court found that “under the circumstances of the [A]ct, ‘appropriate’ can be taken to mean care similar to care that would have been provided to any other patient, or at least not known by the providers to be insufficient or below their own standards.” \textit{Id.}
\textsuperscript{68} \textit{Petrovics}, 764 F. Supp. at 418. The court also noted that at the time of discharge, the plaintiff's condition was not worsening. Therefore, to Prince William Hospital, plaintiff was stable.
one million dollars on damages for medical malpractice does not apply to a claim under COBRA. The court allowed plaintiff to state a COBRA claim for one hundred eighty million dollars for a hospital's failure to diagnose septic shock when plaintiff was presented to its emergency room. The court ruled that plaintiff was entitled to recover those damages allowed under state law but that she was not limited to the statutory ceiling on recovery.

These cases clearly demonstrate a broad construction of COBRA. These cases send a forceful message to hospitals in the Commonwealth that they must provide medical screening and stabilize or transfer individuals, including the uninsured, whether they originally come to the emergency room or elsewhere. Indeed, the decision in Smith indicates a level of sensitivity to this issue in the courts that may result in a significant expansion of hospital liability.

IV. HOSPITAL/MEDICAL STAFF RELATIONS

The relationship between hospitals and medical staffs continues to become more complex with the proliferation of managed care plans, ratcheting down of payment by insurers and more intense competition among all health care providers. Nowhere is this more visible than in the area of credentialing of physicians for privileges on the hospital medical staff. The concept of "economic credentialing" is a major topic of discussion in health care literature and, increasingly, the courts.

The U.S. Court of Appeals for the Fourth Circuit grappled with the antitrust implications of medical staff credentialing and allegations of "economic credentialing" in a recent case. In Oksanen v. Page Memorial Hospital, the court ruled that members of a hospital medical staff are capable of (but were not in this instance found to be) conspiring among themselves when making decisions.

72. Id. at *13.
75. 912 F.2d 73 (4th Cir. 1990), superseded on reh'g, 945 F.2d 696 (4th Cir. 1991) (en banc), cert. denied, 112 S. Ct. 973 (1992).
which affect a physician's medical staff privileges, thereby implicating the antitrust laws. 76

The appellant in Oksanen moved to Luray in Page County, Virginia in 1978 to practice family medicine. Rejecting an offer to practice medicine with one of the physician defendants, Dr. Holsinger,77 appellant opened his own office as a sole practitioner. After a one year probationary period, appellant received full medical staff privileges at Page Memorial over the objections of Dr. Holsinger.

From 1979 to 1983, the hospital administration received numerous complaints about appellant's alleged abusive conduct toward nurses, laboratory staff and administrative personnel.78 In addition, appellant complained that his physician colleagues were performing surgeries that should have been performed elsewhere. In response to these complaints, the hospital administrator in mid-1983 requested that the medical staff investigate the situation. Subsequently, the medical staff determined that no disciplinary action was warranted.79

Shortly thereafter, two additional incidents with the medical staff allegedly occurred, after which the executive committee of the medical staff voted to revoke appellant's staff privileges.80 However, after appellant protested, the board of trustees of the hospital voted merely to suspend appellant's privileges for two months, followed by a one-year probationary period.81

Appellant's return to practice was not smooth and complaints about him arose again. In mid-1984, the executive committee of the medical staff recommended to the board that appellant's staff privileges be revoked permanently. However, Oksanen resigned from Page Memorial's medical staff in June 1984, prior to the board's final decision.82

In 1988, appellant filed a complaint alleging antitrust claims under sections 1 and 2 of the Sherman Act83 and asserting pendent

---

76. 945 F.2d at 711.
77. Id. at 696. Three other physicians and Page Memorial Hospital were also defendants in this case.
78. Id. at 700-01.
79. Id. at 700.
80. Id. at 700-01.
81. Id. at 701.
82. Id. at 701-02.
state claims for violations of the Virginia Antitrust Act, civil conspiracy, tortious interference with contract and defamation. 84

Oksanen's section 1 antitrust claim alleged that the physician defendants conspired among themselves and with the defendant hospital to deprive Oksanen of his medical staff privileges and access to the hospital's ancillary facilities following his resignation from the medical staff in 1984. Oksanen alleged that while this conspiracy occurred under the guise of peer review it was, in fact, a concerted effort to exclude him from the hospital medical staff and irreparably damage his medical practice in Luray. Oksanen's section 1 claim alleged that defendants possessed monopoly power in Page County and used that power to Oksanen's economic detriment. 85 Oksanen also alleged that the defendants conspired to injure his trade or business in violation of Virginia Code section 18.2-500. 86

The district court, in a memorandum opinion, granted defendant's motion for summary judgment. 87 A three-judge panel of the Fourth Circuit reversed the district court's grant of summary judgment and remanded. 88 The court ruled that the defendants were legally capable of conspiring since they constituted independent entities. 89 The court further ruled that the trial court had not permitted sufficient discovery in order to support the grant of sum-

86. See VA. CODE ANN. § 18.2-500 (Repl. Vol. 1988 & Cum. Supp. 1992). In order to prevail under this section of the Code, a plaintiff must prove that two or more persons combined for the purpose of wilfully and maliciously injuring plaintiff's trade or business. Plaintiff must also allege he suffered actual damage as a result of the actions of the alleged conspirators. Plaintiff further complained that the defendants tortiously interfered with his contractual relationships with the hospital, his patients and a local nursing home for which he provided medical services. Cf. Allen Realty Corp. v. Holbert, 227 Va. 441, 449, 318 S.E.2d 592, 596-97 (1984).
87. No. 88-0166-H, 1989 U.S. Dist. LEXIS 18035, at *1 (W.D. Va. June 16, 1989). The extensive memorandum opinion of the District Court treated each of Oksanen's complaints in detail. The court essentially found that notwithstanding the fact that Oksanen had not been allowed to conduct extensive discovery, the claims failed as a matter of law because Oksanen failed to produce sufficient evidence of a conspiracy among the individual defendants. Therefore, the court did not consider application of the intracorporate immunity doctrine. Id. at *33.
89. See id. at 77.
mary judgment at that time. The full Fourth Circuit granted a rehearing en banc and reversed the panel's holding thereby sustaining the dismissal of Oksanen's claims.

On rehearing, the Fourth Circuit held that Oksanen's section 1 claim must be dismissed on the basis of the intracorporate immunity doctrine. Because both the hospital and its medical staff shared a unity of interest, namely upgrading the quality of patient care, the court found that they constituted a single entity, immune from section 1 scrutiny. Dismissing appellant's claim that the medical staff and hospital were legally separate entities, unlike a corporation and its officers, the court emphasized examination of the substance, rather than the form, of the relationship between the hospital and the medical staff during the peer review process. Examining the relationship between the hospital and its staff, the court concluded that the two were similar to a corporation and its officers. By delegating authority to its medical staff to conduct peer review, the hospital acted similarly to a corporation that delegates authority to its officers. In this way, the medical staff was acting merely as an agent of the hospital board of trustees. The Oksanen court concluded that such delegation of authority does not implicate section 1 scrutiny.

The degree of control exercised by the hospital over the medical staff during the peer review process was an important element in the court's opinion that the hospital and the medical staff acted as a single enterprise. The power of the hospital board of trustees to modify the decisions of the medical staff was significant to the

90. See id. at 79.
92. See id. at 703.
93. See id. at 708. The intracorporate immunity doctrine was articulated by the United States Supreme Court in Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752 (1984). Copperweld noted that unilateral actions of a single enterprise are immune from § 1 scrutiny, despite any corresponding restraint on trade. Id. at 767. To give an example of unilateral conduct, the Copperweld court expressed that "[t]he officers of a single firm are not separate economic actors pursuing separate economic interests, so agreements among them do not suddenly bring together economic power that was previously pursuing divergent goals." Id. at 769.
94. Oksanen, 945 F.2d at 703.
95. Id. The court determined that since conducting peer review does not join independent economic forces, § 1 is not violated. Id. On the contrary, the court noted that the medical staff was "a natural component of the hospital's management structure." Id.
96. See id. at 704. The Oksanen court pointed out "the parent corporation's ability to exercise control over its subsidiary . . ." in Copperweld influenced the U.S. Supreme Court's decision that the two entities were a single enterprise. Id.
court in determining that the revocation of Oksanen’s privileges was the product of a single enterprise, not two distinct entities.\(^9\)

A limited exception to the intracorporate immunity doctrine does exist.\(^8\) Under the exception, a corporation can conspire with its officers or agents “when the officer has an independent personal stake in achieving the corporation’s illegal objective.”\(^9\) However, if the officer with the independent interest possesses no significant degree of control over the decision-making process, then no antitrust concerns are raised.\(^10\) Since the members of the medical staff in \textit{Oksanen} had only indirect economic interests and the board of trustees retained authority over medical staff decisions, the Fourth Circuit declined to invoke the “personal stake” exception.\(^11\)

Evaluating the “restraint of trade” portion of section 1 analysis, the court emphasized that hospitals would not typically conspire to restrain the number of physicians since their interests would be inhibited.\(^12\) Since hospitals have incentive to increase the number of admissions and physicians ultimately control where their patients are admitted, hospitals would want to increase the number of physicians with staff privileges.\(^13\) Because Page Memorial suffered a decrease in admissions during the 1980s, it would not have had the incentive to revoke Oksanen’s staff privileges without good reason.\(^14\)

Although acknowledging that individual members of a medical staff have the capacity to conspire among themselves,\(^15\) the court found no evidence that Page Memorial’s medical staff conspired to oust Oksanen.\(^16\) Rejecting appellant’s suggestion that the medical

\(^{97}\) See id.


\(^{99}\) Id.

\(^{100}\) \textit{Oksanen}, 945 F.2d at 705; see PHILLIP AREEDA, ANTITRUST LAW \$ 1471d, g (1986).

\(^{101}\) \textit{Oksanen}, 945 F.2d at 705-06.

\(^{102}\) Id. at 704.

\(^{103}\) See id. This analysis is countered by those who caution against the judicial sanctioning of “economic credentialing.” Some might argue that a hospital medical staff could be motivated to exclude new physicians who will compete with established physicians for market share. A hospital board could be urged to acquiesce in this plan to maintain good relations with established members of the medical staff who account for a significant volume of admissions.

\(^{104}\) See id.

\(^{105}\) See Nurse Midwifery Assocs. v. Hibbett, 918 F.2d 605, 614 (6th Cir. 1990) (finding that in certain circumstances the intracorporate conspiracy doctrine “does not preclude a conspiracy among individual members of the medical staff”).

\(^{106}\) \textit{Oksanen}, 945 F.2d at 706.
staff's action against him through peer review proceedings demonstrated the existence of a conspiracy, the court opined that "mere contacts and communications, or the mere opportunity to conspire . . . is insufficient evidence from which to infer an antitrust conspiracy in the context of the denial of hospital . . . privileges." 107 The court noted that the claimant must produce evidence that the medical staff made a conscious effort to coerce the hospital into accepting its recommendation. 108 The court found no such proof in this case. 109

Appellant also contended that defendants violated section 1 of the Sherman Act 110 when they allegedly monopolized and conspired to monopolize the health care market in Page County. 111 The court noted that the appellant failed to provide evidence that Page County was the relevant market allegedly monopolized by defendants, especially since appellant referred a large number of patients to hospitals outside of Page County.

Even if appellant could prove the existence of monopoly power, the court concluded that he would be unable to demonstrate that the hospital willfully acquired or sought to maintain such power since the hospital had legitimate reasons for revoking appellant's staff privileges. 112 Finally, the court summarily dismissed appellant's pendent state law claims. 113

The Fourth Circuit's reluctance to apply antitrust scrutiny to medical staff peer review decisions reveals its willingness to allow hospitals discretion in promoting the quality of patient care. This decision surely relieves Virginia hospitals conducting peer review proceedings. However, the Fourth Circuit did point out that mem-

---

107. Id. (quoting Cooper v. Forsyth County Hosp. Auth., 789 F.2d 278, 281 (4th Cir. 1986)).
108. Id. at 706.
109. The court noted that the conduct at issue was legitimate and fair. Under the law, peer review proceedings are mandatory. In addition, the medical staff initially shied away from taking formal disciplinary action against appellant. The court also rejected appellant's contention that the defendants conspired against him outside of the peer review process. Id. at 706-07.
111. Section 1 prohibits the acquisition of monopoly power and the use of such power to the detriment of competitors. Usually examined under a "rule of reason" standard, the analysis must consider any pro-competitive benefits and conduct undertaken for legitimate business reasons. Oksanen, 945 F.2d at 709.
112. Id. The court also rejected appellant's argument that the medical staff conspired among itself and with the hospital to monopolize the medical services market. Id.
113. See id. at 710-11.
bers of a hospital medical staff are capable of conspiring among themselves and health care providers in the Commonwealth should be on guard.

V. TAX-EXEMPT ORGANIZATIONS

In General Counsel Memorandum 39,862 (GCM), the Internal Revenue Service's (IRS) Chief Counsel's Office overturned three private letter rulings, which approved specific hospital-physician joint ventures involving sale of part of the hospitals' net revenue streams. In GCM 39,862, the IRS concluded that the transactions it had approved in the three private letter rulings were inconsistent with the hospitals' tax exempt status under section 501(c)(3) of the Internal Revenue Code of 1986 (IRS Code) for at least three reasons. First, formation of a joint venture with medical staff physicians causes the hospitals' net earnings to inure to private individuals. Second, the benefit to private individuals cannot be considered incidental to the public benefits achieved. Third, such transactions may violate other federal laws.

While revocation of the three private letter rulings technically applies only to the three hospitals involved, GCM 39,862 has broad implications. The IRS, in analyzing the three letter rulings, rejected certain justifications which the hospitals had relied on in structuring joint venture arrangements. The analysis proffered in GCM 39,862 applies to all joint ventures and physician incentive arrangements in which tax exempt hospitals participate.


115. Priv. Ltr. Ruls. 89-20-093, 89-42-099, and an unpublished 1984 ruling. A LTR stands for "private letter ruling;" issued by the IRS National Office. It applies the law to a specific factual situation at the request of a specific taxpayer. Although important, these letter rulings do not bind the IRS in dealings with other taxpayers.

116. See I.R.C. § 501(c)(3)(1988) ("Corporations, and any community chest, fund or foundation, organized and operated exclusively for . . . charitable, scientific . . . purposes . . . , no part of the net earnings of which inures to the benefit of any private shareholder or individual . . . .").

A. The Three Private Letter Rulings

In a 1984 unpublished letter ruling, the IRS issued a favorable ruling to a tax-exempt nonprofit hospital proposing to sell its net revenue stream from the operation of certain outpatient departments. In an effort to increase utilization of certain outpatient facilities, the hospital proposed to establish a for-profit stock corporation which would be jointly owned, in equal shares, by the hospitals and physicians on staff. The new corporation would serve as general partner in four limited partnerships formed specifically to allow medical staff physicians to participate in the operation of four hospital outpatient departments.\footnote{118. *Id.* at *9. The outpatient departments involved were surgery, diagnostic (CT scan, ultrasound, etc.), ophthalmology and cardiac nuclear medicine. Aggregated, these departments represented roughly 4% of the hospital's gross revenues.}

Under the proposal, the hospital would lease outpatient departments to the limited partnerships for a stated period of time. In turn, the limited partnerships would pay the hospital a fixed price, discounted to present value, for the revenue stream of each department.\footnote{119. *Id.* at *10. The limited partnerships would also pay the hospital a fee for managing the departments and reimburse the hospital for all fixed and variable costs incurred in operating the departments. *Id.*} Because the physician-investors shared profits above the level already received by the hospital, they would only benefit if utilization of the specific outpatient departments increased.

The arrangement provided that although fifty percent of each limited partnership would be held by the corporation and fifty percent would be sold to the physicians, the hospital would retain actual control of the outpatient facilities through a management agreement.\footnote{120. *Id.* In addition, the hospital would set the rates for patients utilizing those specific outpatient facilities.} To justify this proposed transaction, the hospital cited its need to increase utilization of its existing facilities and to elevate quality of service while keeping costs low.\footnote{121. *Id.* at *11. The hospital faced competition from two hospitals, one for profit and the other not-for-profit. Also, a private physician was planning to establish freestanding outpatient facilities that would be owned jointly with other physicians. *Id.*} It reasoned that approving the transactions would allow it to further its charitable purposes by creating incentives for medical staff physicians to increase admissions and referrals to other departments.

In the second ruling, private letter ruling 88-20-093, the structure of the transaction was slightly different. There, a tax-exempt
hospital subsidiary formed a limited partnership in which it held ten percent as a general partner and forty percent as a limited partner.\textsuperscript{122} Medical staff physicians were also limited partners who initially held the remaining fifty percent of the limited partnership.\textsuperscript{123}

The limited partnership planned to purchase the net revenue stream of the hospital’s outpatient surgery program and gastroenterology laboratory.\textsuperscript{124} The revenues originally were bought for a term of five years with an option to extend the contract for an additional five years.\textsuperscript{125} According to the hospital subsidiary, the purchase price for the revenue stream was agreed upon after arm’s length negotiations.\textsuperscript{126}

The hospital continued to own and operate the medical facilities under its license and to determine the fees charged to patients. Each quarter, the hospital paid net revenue from operation of the facilities to the limited partnership. The hospital rationalized that this structure encouraged physicians to increase usage of the facilities.

In the third ruling, private letter ruling 98-42-099, a hospital proposed to form a limited partnership with JV Corp., a joint venture planning entity.\textsuperscript{127} The hospital and JV Corp. planned to serve as general partners.\textsuperscript{128} The hospital and medical staff physicians together would hold ninety-nine percent of the limited partnership,\textsuperscript{129} although the hospital alone would have a fifty percent share. Ownership interests and partnership allocations would be

\textsuperscript{122} Priv. Ltr. Rul. 88-20-093 (Feb. 26, 1988). The hospital donated to the subsidiary funds to purchase its interest in the limited partnership and to establish a loss reserve.

\textsuperscript{123} Id. Ultimately, the physicians may have held ninety percent of the limited partnership.

\textsuperscript{124} Id.

\textsuperscript{125} Id. The option could be exercised by a fifty-one percent vote of the physicians’ limited partner interest.

\textsuperscript{126} This price was fixed at fair market value and discounted to present value. Id.

\textsuperscript{127} Priv. Ltr. Rul. 89-42-099 (July 28, 1989). The joint venture entity was owned equally by the hospital and its medical staff. JV Corp. planned to serve as the managing partner for the limited partnership.

\textsuperscript{128} Id. Jointly, the general partners would own only one percent of the limited partnership.

\textsuperscript{129} Id. Limited partnerships would be purchased only by general partners and sold to licensed physicians who were both members of the hospital’s medical staff and shareholders in JV Corp. All physicians on the hospital medical staff would be eligible to invest in the limited partnership and would be required to invest a minimum of five thousand dollars. According to the hospital, the minimum investment requirement would save “each investor a substantial risk of loss.” Id.
based only on capital accounts, rather than on patient referrals to the hospital. Like the hospital subsidiary in the second letter ruling, this hospital planned to operate the outpatient surgery facility under its license.

Under the agreement, the limited partnership would obtain a nonexclusive right to use the outpatient surgery facility and equipment. In addition, the limited partnership would acquire the gross revenue stream generated from operation of the facilities. The agreement initially covered a term of five years, and included an option to extend the deal for an additional five years. The contract provided for the hospital to pay the limited partnership adjusted gross revenues earned by the outpatient surgery program each quarter. In turn, the limited partnership agreed to pay the hospital on a quarterly basis for operating the facility.

B. The Legal Analysis

The use of joint venture arrangements has increased dramatically due to the shift in governmental policy away from regulatory cost controls toward encouraging competition among health care providers. Since many medical and surgical procedures which were formerly performed on an inpatient basis can now be done in an outpatient clinic, physicians are increasingly able to compete with hospitals for certain types of services. In addition, the federal Medicare program has shifted from cost-based reimbursement to fixed, per-case, prospective payments for inpatient care. Finally, the number of inpatient admissions and the average length of stay have declined significantly. These changes have left hospitals searching for ways to increase patient admissions and to identify alternate sources of revenue and capital.

Joint venture arrangements provide one mechanism for achieving some of these goals.

Despite the many justifications offered by hospitals for forming joint venture arrangements, the IRS is still strictly scrutinizing transactions in which charitable organizations and private individ-

---

130. Id. The gross revenue stream acquired did not include bad debts or contractual allowances and excluded the physician's professional fees.
131. Id. The option could be exercised by JV Corp.
132. Id. While a diagnosis-related prospective payment system (PPS) provides strong incentives to decrease the length of patients' hospital stays and controls the cost of each patient's care, it creates incentive to increase admissions.
uals jointly participate. In reviewing the three private letter rulings discussed previously, the IRS concluded that they jeopardized a hospital’s tax exempt status for three reasons. Each of these reasons will be discussed in turn.

1. Private Inurement

Section 501(c)(3) of the Internal Revenue Code defines a charitable organization as one in which “no part of the net earnings . . . inures to the benefit of any private shareholder or individual.” The regulations accompanying section 501(c)(3) state that a hospital is not operated exclusively for one or more exempt purposes if any part of its net earnings inures to the benefit of private shareholders. A “private shareholder or individual” is defined as a “person . . . having a personal and private interest in the activities of the organization,” and is commonly referred to as an “insider.”

In a 1986 ruling, the IRS emphasized that medical staff physicians are subject to the inurement prohibition. According to that decision, staff physicians have close working relationships with hospitals and may control the flow of patients to and away from the facility. In addition, they impact the level of patient utilization of hospital services. Consequently, once a joint venture commences, each physician-investor becomes an “insider.”

Although physicians are subject to the inurement proscription, financial transactions are still permitted between the doctors and the hospital. For example, physicians may be paid reasonable compensation for services provided. The proscription is designed to eliminate “dividend-like distributions” of charitable assets to benefit a private interest. Such arrangements will destroy a hosp-

138. See Birmingham Business College, Inc. v. Comm’r, 276 F.2d 476, 480 (5th Cir. 1960) (while the payment of reasonable compensation did not constitute earnings inuring to the benefit of those who created a tax exempt organization, use of compensation to insure an equal distribution of earnings to the shareholders did constitute an inurement); Mabee Petroleum Corp. v. United States, 203 F.2d 872 (5th Cir. 1953) (payment of reasonable salaries to corporate officers did not constitute inurement of net corporate assets; however, excessive and unreasonable salaries would constitute an inurement).
tal’s exemption if they are “merely a device for distributing profits to persons in control.”\textsuperscript{140}

The inurement prohibition applies not only to a hospital’s net earnings but also to any of its charitable assets.\textsuperscript{141} Likewise, net earnings may inure to a private individual in ways other than the distribution of dividends.\textsuperscript{142} In addition, even small amounts may violate the inurement prohibition.\textsuperscript{143}

In assessing the three private letter rulings, the IRS suggested that the proper starting point in the analysis is to determine whether the transaction furthers the hospital’s exempt purposes.\textsuperscript{144}

Finding no expansion of health care resources and no creation of new providers, the IRS concluded that the transactions did not further charitable purposes.\textsuperscript{145} Instead, the IRS hypothesized that the hospitals engaged in these joint ventures in order to financially reward and retain medical staff physicians, to increase admissions and referrals, and to prevent the creation of competing services by physicians.\textsuperscript{146} Finding that giving or selling medical staff physicians a proprietary interest in the net profits of a hospital is indistinguishable from paying dividends on stock, the IRS concluded that the arrangements per se violated the inurement prohibition of section 501(c)(3).\textsuperscript{147}

2. Private Benefit

Tax exempt organizations must serve a public rather than a private interest.\textsuperscript{148} Unlike the inurement proscription which applies only to “insiders,” the private benefit prohibition extends to all persons and groups.\textsuperscript{149} In addition, while the private inurement prohibition is absolute,\textsuperscript{150} the private benefit prohibition is not ap-
plied where the private benefit is incidental to the public benefit conferred.\textsuperscript{151}

The prohibitions against inurement and private benefit are separate and distinct. While the presence of private inurement violates both proscriptions, the absence of inurement does not signify the absence of private benefit.\textsuperscript{152} This distinction is important because even if a hospital has been cleared of violating the inurement prohibition, the IRS will still apply the private benefit test to the transaction at issue.

The presence of a single substantial noncharitable purpose constitutes private benefit and will destroy exemption even if greatly outnumbered by charitable purposes.\textsuperscript{153} A balancing test is employed to determine the existence of a substantial noncharitable purpose.\textsuperscript{154} According to the IRS, the prohibition is not violated as long as the private benefit is incidental in both a qualitative and quantitative sense to the overall benefit.\textsuperscript{155} The private benefit is balanced only against the public benefit, not the overall good accomplished by the organization.

Private benefits conferred on physician-investors by the revenue stream from joint ventures are not incidental, but are direct and substantial. In support of this proposition, the IRS noted that the public benefits expected from these transactions, namely better financial health or greater efficiency, only tenuously relate to hospitals' charitable purposes of promoting community health. The IRS stated that while increased referrals or prevention of new competition may enhance the competitive position of a specific hospital, it does not necessarily further charitable goals.\textsuperscript{156}

In addition to analyzing the sale of revenue streams, in GCM 39,862 the IRS also addressed the joint venture aspect of these transactions. Noting that this aspect of the law has changed significantly over the last decade, the IRS asserted that it no longer as-

\textsuperscript{151} See id. § 1.501(c)(3)-1(d)(1)(ii). For a discussion of a situation in which more than incidental private benefit was involved, see Sonora Community Hosp. v. Commissioner, 46 T.C. 519 (1966), aff'd, 397 F.2d 814 (9th Cir. 1968).

\textsuperscript{152} See American Campaign Academy v. Commissioner, 92 T.C. 1053 (1989).


\textsuperscript{155} Gen. Couns. Mem. 39,862 (Nov. 22, 1991). Noting that "some private benefit is present in all typical hospital physician relationships," the IRS has concluded that "[t]he private benefit accruing to physicians generally can be considered incidental to the overwhelming public benefit."

\textsuperscript{156} Id.
sumes that participation as a general partner in a partnership is per se incompatible with exemption. Instead, when private, taxable parties are involved, the IRS will scrutinize the transaction for private inurement or private benefit using a "careful scrutiny" standard of review. In order to pass muster, the joint venture organization must further a charitable purpose and must only incidentally benefit the partner if at all.

Applying the close scrutiny standard, the IRS concluded that the partnerships at issue do not serve charitable purposes. The IRS reasoned that the partnership's only function is to purchase, receive and distribute the net revenue stream, not further a charitable end. Thus, the arrangements failed the first step of the close scrutiny standard. Even if the joint ventures crossed the first hurdle, they would stumble over the second because the arrangements benefit the private interests of the physicians too greatly to be incidental.

3. Federal Law Violations

Since almost every exempt hospital described in section 501(c)(3) participates in the Medicare and Medicaid programs, almost all hospitals are subject to the Social Security Act. Especially significant is the anti-kickback statute, a portion of the Medicare and Medicaid anti-fraud and abuse law. The anti-kickback statute prohibits the offer, solicitation, payment or receipt of any remuneration in return for, or to induce, the referral of a patient for any service that may be paid for by Medicare or Medicaid. How the statute applies to hospital physician joint ventures has yet to be firmly established. A hospital violating this prohibition may jeopardize its exemption.

The Secretary of HHS has published regulations which specify payment practices that do not violate the anti-kickback statute. The safe harbor regulations protect only a few existing practices that meet very precise standards and are clearly non-abusive. It

157. Id.
158. Id.
160. Id.
covers investments in larger publicly traded entities\textsuperscript{162} and certain active and passive investments in small entities.\textsuperscript{163} The investments at issue here were not covered and would have to meet the eight standards to be protected. The arrangements failed to satisfy the standards.\textsuperscript{164}

Regarding the arrangements at hand, the IRS concluded that engaging in any conduct violative of the anti-kickback statute was incompatible with charitable exemption status. Specifically, the IRS intimated that the physician-hospital arrangements were not true joint ventures, but shams.\textsuperscript{165} A valid business purpose is necessary to avoid fraud and abuse problems in joint ventures.\textsuperscript{166} Joint ventures amount to a sham when they are created to pass an economic benefit in exchange for referrals,\textsuperscript{167} and absence of mutual risk generally indicates a sham operation.\textsuperscript{168}

Lack of symmetry in upside opportunities and downside risks for physician investors makes the arrangements at issue suspect. The arrangements characterize a great potential for reward, but little downside risk for the physicians. Instead, most of the risk was borne by the general partners. The IRS suggested that just having the opportunity to invest in such a profitable venture to which the physician would be referring patients could be reviewed as illegal remuneration in violation of the anti-kickback statute.\textsuperscript{169} The IRS, however, declined to specifically rule on this issue.

VI. Health Care Decisions Act

The 1992 General Assembly session continued to address the rights of individuals to make decisions to have medical treatment withheld in certain cases. Virginia, like many states, adopted “right-to-die” legislation in the 1980s to empower individuals suffering from “terminal illnesses,” or persons in a “persistent vegetative state,” to order that certain medical care be withheld or with-

\textsuperscript{162} 42 C.F.R. § 1001.952(a)(1). Application is restricted to publicly traded investments in entities having undepreciated net tangible assets exceeding $50 million.
\textsuperscript{163} Id. See 42 C.F.R. § 1001.952(a)(2) for a list of the standards.
\textsuperscript{166} Id.
\textsuperscript{167} Sanford Teplitzky, Avoiding Fraud and Abuse Problems in Joint Ventures, 4 HealthSpan 17 (Jan. 1987).
\textsuperscript{168} Id.
In addition to the Natural Death Act, two other sections of the Code, section 37.1-134.4 and sections 11-9.1 and -9.2, dealt with various aspects of advance decisionmaking through the appointment of surrogate decisionmakers. This patchwork of legislation created some confusion and led to different approaches to planning for incapacity.

The Health Care Decisions Act\textsuperscript{172} creates a single "advance directive" statute thus eliminating the inconsistencies between the Natural Death Act and Code section 37-1..-134.4\textsuperscript{173} relating to persons who may consent to treatment for individuals incapable of consenting for themselves at the time.\textsuperscript{174} The impetus for the Health Care Decisions Act derived, in part, from the Federal Patient Self-Determination Act\textsuperscript{175} which requires:

(1) hospitals, skilled nursing facilities, home health agencies, hospice programs, and HMOs which participate in Medicare and Medicaid programs to inform patients of their rights under state law to make treatment decisions;

(2) health care providers to educate staff and the community about advance directives;


\textsuperscript{171} VA. CODE ANN. § 37.1-134.4 (Repl. Vol. 1990) (repealed), 11-9.1, -9.2 (Repl. Vol. 1989). Former § 37.1-134.4 created a statutory alternative to the Natural Death Act and common law for the appointment of surrogate decisionmakers. It provided that if a physician determined that "[b]ecause of mental illness, mental retardation, or any other mental disorder, or a physical disorder which precludes communication or impairs judgment, [a patient] is incapable of making an informed decision about providing, withholding or withdrawing a specific medical treatment or course of treatment . . . ." the physician could rely upon the instructions of a surrogate decisionmaker. \textit{Id.} § 37.1-134.4 (Repl. Vol. 1990). The classes of surrogate decisionmakers, and their priorities, were set forth in the statute. Sections 11-9.1 and -9.2 permit the creation of so-called "durable" powers of attorney which are designed to survive the incapacity of the principal. \textit{Id.} §§ 11-9.1, -9.2 (Repl. Vol. 1989).


(3) states to establish a written description of the state's law concerning advance directives for distribution by providers; and

(4) the Secretary of Health and Human Services to develop and implement a nationwide education campaign.176

The Health Care Decisions Act expands the options for the form of the advance directive by adding a durable power of attorney provision to the living will choice.177 Under the new provision, an agent may be appointed to make health care decisions, as provided in the written advance directive, for declarants determined to be incapable of making an informed decision.178 If the agent cannot determine which treatment the declarant would have chosen, the agent is authorized to make a decision based upon the best interest of the patient.179 The agent's authority is effective as long as the declarant is incapable of making an informed decision.180

In the absence of an advance directive, the procedure differs. In this situation, an attending physician may either provide, withhold, or withdraw medical treatment from a patient incapable of making an informed decision upon the authorization of persons in a specified order of priority.181 The physician, however, still has some flexibility. If the physician knows that the course of treatment authorized by the specified individuals is protested by the patient, the physician is not compelled to provide it.182 As part of the new statute, the specified persons must make the medical treatment decision based upon guidelines set out by the Act.183 No person or facility treating a patient with proper authorization will incur liability for any claim based on lack of consent or authorization for such treatment.184 Likewise, persons authorizing treatment in accordance with the Act will not be subject to criminal prosecution, civil liability or liability for the cost of treatment.185

By combining the Natural Death Act and section 37.1-134.4 of the Code, the General Assembly eliminated inconsistencies regard-

176. Id.
178. Id.
179. Id.
180. Id.
181. Id. § 54.1-2986(A).
182. Id. § 54.1-2986(C).
183. See id. § 54.1-2986(A).
184. Id. § 54.1-2988.
185. Id.
ing authorization for treatment of individuals incapable of consenting for themselves. Under the former Natural Death Act, only those competent adults diagnosed as having a terminal condition could make a written or oral declaration. In 1989, the General Assembly revised the Natural Death Act to permit those declarants terminally ill or unable to make or communicate a decision to designate a person to make treatment decisions for them.\textsuperscript{186} The “substituted consent” statute, however, did not require the individual to have a terminal illness.\textsuperscript{187}

Finally, the Health Care Decisions Act incorporates a new provision allowing emergency medical services personnel to follow Emergency Medical Services “Do Not Resuscitate Orders”\textsuperscript{188} in the pre-hospital setting.\textsuperscript{189} The “Do Not Resuscitate Order” itself is a written physician’s order, validated by a form or bracelet approved by the Board of Health, which authorizes qualified emergency medical service personnel to withhold cardiopulmonary resuscitation from adult patients in the event of cardiac or respiratory arrest.\textsuperscript{190} The order, however, does not authorize the withholding of other medical interventions, such as intravenous fluids, oxygen or other therapies necessary to provide comfort, care, or to alleviate pain.\textsuperscript{191}

\section*{VII. Fraud and Abuse Developments}

Like the other areas of health law, the past year saw significant activity with respect to fraud and abuse.\textsuperscript{192} This past year alone,

\begin{footnotesize}
\begin{enumerate}
\item This provision was outlined in the now repealed Va. Code Ann. § 37.1-134.4 (Repl. Vol. 1990). See supra note 173.
\item Emergency medical personnel are not authorized to follow such orders if the patient is able to and does express to such personnel a desire to be resuscitated prior to cardiac or respiratory arrest. Id.
\item Id. § 54.1-2982. The term “cardiopulmonary resuscitation” is defined to include cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, and defibrillation and related procedures. Id.
\item Id.
\item The federal Medicare and Medicaid fraud and abuse law also referred to as the anti-kickback statute, is codified at 42 U.S.C. § 1320a-7b (1988 & Supp. II 1990). Virginia also has a series of similar state laws which address fraud and abuse issues. Section 32.1-315 prohibits the knowing and willful solicitation, receipt, offer or payment of remuneration in return for referring a person for an item or service paid for under the Commonwealth’s Medicaid program. Va. Code Ann. § 32.1-315 (Repl. Vol. 1992). Two statutes prohibit the knowing and willful offer or payment of remuneration by a hospital or institution for the
\end{enumerate}
\end{footnotesize}
final fraud and abuse safe harbor regulations were promulgated, a fraud alert and a management advisory report were issued by the HHS Office of the Inspector General, and the first administrative exclusion case under the fraud and abuse law was prosecuted. These recent events have fueled the concerns of health care providers about both the reach and the impact of the statute.

Federal fraud and abuse law broadly prohibits the offer or receipt of remuneration, directly or indirectly, in cash or in kind, for the purpose of inducing referrals for items or services paid for by Medicare or Medicaid programs. Remuneration is not limited to cash bribes or kickbacks; rather, remuneration includes forgiveness of indebtedness, reduced rent, in-kind payments, free services, or any other item or service of value.

Federal courts have construed this statute broadly, finding that if one purpose of remuneration paid to a health care provider is to induce a referral, the statute has been violated, regardless of whether valuable items or services were provided in return for the remuneration. Because of the breadth with which the judiciary has interpreted the statute, Congress directed the Secretary of Health and Human Services to promulgate safe harbor regulations to define certain conduct which would not be subject to prosecution under the statute. The final safe harbor regulations, pub-

195. Greber, 760 F.2d 68; see also United States v. Kats, 871 F.2d 105 (9th Cir. 1989); United States v. Bay State Ambulance, 874 F.2d 20 (1st Cir. 1989).

(a) Regulations. The Secretary of Health and Human Services, in consultation with the Attorney General, not later than 2 years after the date of the enactment of this Act [enacted Aug. 18, 1987] shall publish proposed regulations, and not later than two years after the date of the enactment of this Act [enacted Aug. 18, 1987] shall promulgate final regulations, specifying payment practices that shall not be treated as a criminal offense under § 1128B(b) of the Social Security Act and shall not serve as the basis for an exclusion under § 1128(b)(7) of such Act. Any practices specified in regulations pursuant to the preceding sentence shall be in addition to the practices described in subparagraphs (A)-(C) of § 1128B(b)(3).

Id. (to be codified at 42 U.S.C. § 1320a-7b).
lished on July 29, 1991 by the Department of Health and Human Services Office of the Inspector General (OIG), define eleven types of arrangements which will not be considered abusive if strict criteria are met. To qualify for safe harbor protection, a provider must meet each criterion of every applicable safe harbor.

The failure to comply with a safe harbor does not necessarily establish a violation of the statute. The preamble to the final safe harbor regulations states that the failure of a transaction to fall within one of the eleven safe harbors could mean one of three things: (1) the conduct is not illegal and thus is not proscribed by the statute, (2) the conduct constitutes a clear violation of the statute and does not qualify for safe harbor protection or (3) the conduct may violate the statute in a less serious manner such that the OIG would exercise its prosecutorial discretion and not prosecute the provider.

Many commentators have predicted that the publication of the safe harbor regulations will usher in an era of heightened administrative prosecution by the OIG. One very visible example of this potential is the OIG's administrative sanction action in the case of Hanlester Network.

The Hanlester case involved a clinical laboratory joint venture arrangement in which physician-investors were chosen specifically for their ability to refer cases. Although investors were not required to refer patients to the entity, they were told that the failure to make such referrals would present a "blueprint for failure." The OIG concluded that the limited partnership interests were sold with the intention of encouraging referrals from the phy-

198. The OIG, a branch of the Department of Health and Human Services, is charged with the civil enforcement of federal fraud and abuse law. The OIG, in conjunction with the Department of Justice, enforces the criminal provisions of the statute. 42 U.S.C. §§ 1302, 1395hh (1988); 42 C.F.R. § 1000.10 to -.30.

199. 42 C.F.R. §§ 1001.1, 1001.951 to -.953. The regulations establish safe harbors for: certain investment interests in both large and small entities, space rental, equipment rental, personal services and management contracts, sale of a practice, referral services, warranties, discounts, employment relationships, group purchasing organizations, and waiver of certain beneficiary coinsurance and deductible amounts. A comprehensive review of the elements of the eleven safe harbors is beyond the scope of this article.


202. Id. at 27,742.
sician limited partners. Accordingly, the OIG gave notice of exclusion from participation in the Medicare and Medicaid programs.

The excluded parties appealed to an administrative law judge (ALJ). The ALJ’s decision rejected the OIG’s interpretation of the fraud and abuse statute. In essence, the ALJ found that payments made to the investors were made in accordance with the terms of the investment rather than in accordance with the number of referrals made. More specifically, the ALJ found that physician partners were not obligated to refer to the partnership laboratories. Absent such a “quid pro quo” agreement, the ALJ refused to find a violation of the fraud and abuse statute.203

On appeal, the Health and Human Services Departmental Appeals Board (DAB) rejected the interpretation of the ALJ, holding that “an agreement precluding provider choice” is not required to establish a fraud and abuse violation. The DAB stated that the term “induce” meant “to exercise influence over reason and judgment in an effort to cause a desired action.”204 The DAB broadly defined remuneration as a “comprehensive reference to anything of value employed with the prescribed intent of inducing referrals.” The DAB remanded the case to the ALJ for an application of the facts to the law.205

On remand, the ALJ adopted the conclusions of law enunciated in the DAB’s decision and found that all respondents had violated the fraud and abuse statute. The ALJ excluded all of the partnerships permanently because they “could not function without referrals from their partners.” The general partner was excluded for two years to provide adequate time to divest itself of the problematic arrangements. The ALJ did not exclude the individual respondents because he found no intent to violate the law given the general state of uncertainty as to the breadth and meaning of the fraud and abuse statute.206

203. Id. at 27,743, 27,745. The ALJ did find that the marketing manager who commented that physician referrals were a requirement of the investment had violated the statute. However, since she had done so in disregard of the instructions of her employer and had subsequently resigned, the ALJ found that no exclusion remedy was necessary. Id. at 27,743.

204. Id. at 27,746-47.

205. Id. at 27,751, 27,764.

On July 24, 1992, the DAB again reversed the ALJ’s decision and concluded that all of the individual respondents should be excluded from participation in the Medicare and Medicaid programs for a period of one to two years. On July 30, the Hanlester Network and the other individually named plaintiffs filed a civil complaint in federal district court seeking to stay the exclusion and reverse the agency’s prior decision. The complaint alleges that the statute is being misused by the OIG to further its position, that the HHS decisions are based on interpretations which are so broad, indefinite and obtuse as to render the anti-kickback statute unconstitutionally vague and overbroad, that the plaintiffs could not have knowingly and willfully violated the statute since they did not and could not have known of the interpretation now being applied, that the decisions were not supported by substantial evidence, and that the DAB improperly usurped the authority of the ALJ by substituting its own judgment for that of the trier of fact. The plaintiffs seek an injunction staying the effective date of the exclusion until the court resolves the substantive issues raised in the case. Hence, at the time of this writing, the ultimate outcome of this exclusion case remains uncertain.

Although the OIG has repeatedly refused to publish advisory opinions which would provide additional clarification with regard to the legality of conduct under the statute, the OIG has been active in issuing fraud alerts and management advisory reports to help define conduct that the OIG considers illegal. In October of 1991, the OIG released a Management Advisory Report discussing suspect arrangements between hospitals and hospital-based physicians. In this report, the OIG concludes that hospitals are in a position to materially influence the flow of Medicare and Medicaid business by selecting the hospital-based physicians who will be the recipients of the flow of business generated at the hospital. Based on its assumption that hospitals can “refer,” the OIG lists a number of suspect arrangements which it believes violates the fraud and abuse statute.

209. Id.
212. See id.
Arrangements cited by the OIG include requirements that hospital-based physicians pay a percentage of their gross receipts to the hospital’s endowment fund; that hospital-based physicians be required to purchase hospital equipment and donate it to the hospital at the termination of the contract; that hospital-based physicians pay for capital improvements, services, supplies, personnel, utilities, maintenance and billing services on a sliding-fee schedule which increases as gross receipts increase; and requirements for free administrative services in exchange for the opportunity to perform and bill patients directly for other services. While the Management Advisory Report created significant controversy, at present, its major impact has been on contractual relationships between hospitals and hospital-based physicians. Hospital-based physicians appear to be increasingly relying on the Management Advisory Report in negotiating contracts with hospitals. It remains to be seen whether the OIG will become active in prosecuting these types of arrangements as violations of the fraud and abuse statute.

The OIG also issued a special fraud alert on May 7, 1992 addressing hospital incentives to physicians. Because the OIG issued a special fraud alert describing in detail the type of arrangement prosecuted in the Hanlester case just prior to that case being brought, many commentators believe that the special fraud alert sends a message that the OIG will be actively seeking to prosecute a case dealing with hospital incentives to physicians. In the fraud alert, the OIG identifies several incentive payment arrangements that it believes may violating the statute. The OIG condemned arrangements ranging from direct payments for admissions to income guarantees, interest-free loans, and free training for physician’s office staff. The OIG warns that financial incen-

213. Id. at 25,216.
214. OIG Special Fraud Alert, “Hospital Incentives to Physicians,” May 11, 1992 (reprinted by Medicare Compliance Alert) [hereinafter “Hospital Incentive Fraud Alert”].
216. The OIG circulated the following list of “indicators of potentially unlawful activity”: payment of any sort of incentive each time a physician refers a patient to the hospital; use of free or significantly discounted office space or equipment; provision of free or significantly discounted staff services; free training for physician’s office staff; income guarantees; low interest or interest-free loans, or loans which may be forgiven; payment of the cost of physician’s travel and conference expenses; payment for continuing education courses; coverage on group health insurance plan at an inappropriately low cost to the physician; payment for services which require few if any substantive duties by the physician. Hospital Incentive Fraud Alert, supra note 214, at 2.
tive packages which incorporate features similar to those named in the fraud alert may be subject to prosecution "if one of the purposes of the incentive is to influence the physician's medical decisions as to where to refer his or her patients for treatment."\footnote{217}

The developments of the past year have created good reason for concern by providers over the scope and meaning of fraud and abuse law. The uncertainty regarding the scope of the statute continues as the \textit{Hanlester} case winds its way through the judicial system, and the limited protection afforded by the long-awaited safe harbor regulations provides little relief for many provider arrangements. The developments that will take place in the coming months will be very important in assessing both the meaning and impact of the anti-kickback statute.

\section*{VIII. Conclusion}

This article has provided a very brief summary of some of the recent developments which are most likely to affect the operations of health care providers in Virginia. Providing legal services to all manner of health care providers continues to increase in complexity, becoming an ever more challenging endeavor.

\footnote{217. Id.}