

Hospital-Physician Joint Ventures

BY TODD C. BROWER, ESQ.

Historically, hospitals and physicians have been partners in the delivery of health care services within hospitals. Unfortunately, that “partnership” has become strained in recent years as more and more services have migrated from the inpatient setting into the ambulatory care setting, and hospitals and physicians compete to provide the same services. A good example of this tug-of-war has occurred in New Jersey, where non-profit hospitals are struggling to maintain profit margins while carrying the burden of providing charity care. With the proliferation of physician-owned ambulatory surgical centers (ASCs), hospitals complain about the “unlevel playing field,” i.e., physician-owned surgery centers are stealing the “good patients” while hospitals are left to absorb the Medicaid, charity care and “no-pay” patients.

The first major assault on physician-owned ASCs in New Jersey came with the enactment of a tax on licensed ambulatory care facilities (ACFs) (which include ASCs) to help finance charity care funding for hospitals. The next assault came from the insurance industry through litigation resulting in a November 2007 court decision (*Garcia versus HealthNet*) declaring that self-referrals to physician-owned ASCs violate New Jersey’s physician referral law, commonly referred to as the Codey Law (discussed further below). The court’s decision initiated a flurry of activity among ASCs, physicians, hospitals, medical societies and the New Jersey Hospital Association, resulting in the legislature’s amendment of the Codey Law to, among other things, create a clear-cut exception from New

Jersey’s ban on self-referrals for existing ASCs. The amended law also created a shotgun wedding of sorts between hospitals and physicians by placing a moratorium on the licensure of new physician-owned ASCs unless the ASCs are co-owned with a New Jersey hospital.



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BENEFITS OF PHYSICIAN-HOSPITAL JOINT VENTURES

Putting aside the unique situation in New Jersey, the time may be ripe for pursuing hospital-physician joint ventures in general. Joint ventures tend to foster better relationships between hospitals and physicians. Moreover, from the perspective of hospitals, a joint venture with physicians provides an opportunity to preserve some of the patient base hospitals believe eroded with the proliferation of physician-owned ACFs and ASCs. From the perspective of physicians, a joint venture with a hospital may provide greater access to start-up capital and enhanced financing options, as well as other physical plant and technological resources.

With regard to capital, hospitals are often able to provide additional sources of capital and access to credit facilities that physicians on their own may not be able to tap into in the current economic climate. While the credit market for single hospitals is shrinking, some health care systems — whether they are state, regional, or national — still have capital resources readily available. Fur-

ther, lending institutions may be more comfortable lending when the borrower entity is a joint venture between physicians and a hospital.

Hospitals also have other resources (e.g., physical plant facilities, technology, and administrative expertise) to bring to the table. In particular, many hospitals are downsizing and have physical plant space that could be utilized for such ventures. While there are regulatory hurdles that need to be cleared, states may be interested in seeing hospitals utilize unused space both because it will provide access to new health care services, and because such use and services will help the hospital’s bottom line, ensuring against continued hospital closures. New Jersey has responded favorably to this concept by agreeing to consider licensure of space within a hospital facility for separate licensure as an ACF, so long as certain regulatory requirements are met. For example, underutilized operating rooms or procedure rooms could potentially be converted for use as a hospital-physician ASC joint venture. By tapping unused hospital space, both parties avoid the lengthy start-up construction phase of a new venture, as well as certain other start-up costs. Hospitals may also have the ability to bring administrative staff and expertise to the venture that would otherwise require the hiring of new and/or additional employees and training, which also reduces start-up time and costs.

The pooling of technological resources is mutually beneficial. The costs associated with technology, whether for new medical equipment or new integrated medical records systems, can be overwhelming for any start-up enterprise—especially so for physicians. By hospitals and physicians pooling their resources, technology costs are more likely to be manageable. With regard to electronic medical records in particular, hospi-

tals are more likely to make a significant capital investment in this technology than individual physicians or even physician groups. In this area, a “techno-partnership” is especially advantageous for physicians.

Significantly, this is also an area that the federal government is looking to help forge hospital-physician collaboration. More specifically, the federal government has created special Safe Harbors under the Anti-Kickback Law that will allow hospitals to expend money on behalf of physicians to promote medical record integration. In addition, under the recently enacted American Recovery and Reinvestment Act (i.e., the President’s Economic Stimulus Package), almost \$20 billion of incentives (mostly through the Medicare Program) have been established to encourage hospitals and physicians to adopt and utilize electronic medical records. Competition for this money will probably be intense, and obviously will require a coordinated effort between hospital and physician partners.

Finally, another significant benefit with hospital-physician partnerships is the ability to share risk. Facing an uncertain economic environment and huge state and federal budget deficits affecting reimbursement policies, spreading the risk between a hospital and physicians in a joint venture provides yet another reason to move in this direction. Not only is there economic risk, but also regulatory risk, as any hospital-physician joint venture must comply with a myriad of state and federal laws, as discussed in further detail below.

STATE LAW ISSUES

As mentioned above, New Jersey has taken an aggressive step in dealing with physician-hospital relationships in the ASC setting. Pursuant to the Codey Law passed in 1991, physicians are prohibited from referring patients for health care services within which they have a financial interest, except in limited circumstances. Senator Codey accomplished on a state-wide basis what Representative Pete

Stark had hoped to accomplish on a national basis, i.e., an outright ban (regardless of payer) on the referral of patients to entities in which the physician has a financial interest. But, just like the Stark Law, a simple concept became exceedingly complicated to interpret and enforce. As discussed above, the recent amendments to the Codey Law have closed the door on new ASCs owned exclusively by physicians, but opened the door to new physician-hospital joint ventures.

Many states have passed physician anti-referral laws similar to the Codey Law or federal Stark Law (discussed below). In addition, many states have passed anti-kickback legislation that impacts hospital-physician joint ventures. Thus, prior to entering into any joint venture relationship, it is imperative to seek legal counsel from experienced health care attorneys.

FEDERAL LAW ISSUES

In addition to state law, there are various federal laws that need to be complied within the formation and operation of a physician-hospital joint venture, including the Anti-Kickback Statute, the Stark law and IRS laws and regulations when dealing with nonprofit hospitals. The government has adopted numerous exceptions and Safe Harbors that provide protection under these laws if a venture is structured in accordance with the exception or Safe Harbor requirements, and has also issued Advisory Opinions and Fraud Alerts that warn about the dangers of improperly structured transactions. While most providers find these laws and regulations confusing and overwhelming, they are manageable, and with proper guidance, a hospital-physician joint venture can be structured to meet the applicable requirements.

From a compliance perspective, the best advice is for hospitals and physicians to get proper guidance from the outset before going too far down the road in their discussions with one another. Often, both hospitals and physicians do not understand the parameters within

which they may structure their relationships. By the time they seek legal guidance, they have already agreed through a handshake (or worse, a signed letter of intent) to terms that will have to be undone in order to make the arrangement legally compliant. Thus, understanding the parameters of a legal joint venture up front can save a lot of time and expense down the road. It also can avoid creating the exact situation the parties hoped to avoid in pursuing a hospital-physician partnership, i.e., strained feelings when the deal has to be restructured to comply with the law.

CONCLUSION

There are great opportunities for hospitals and physicians to collaborate on joint ventures, and sound financial reasons to pursue them. By approaching the process with an understanding of the legal parameters within which the venture can be structured, hospitals and physicians can pursue what should be a natural partnership and move forward together in bringing state-of-the-art services to the patients being served.

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