Becker's ASC Review
Ambulatory Surgery Centers
BUSINESS AND LEGAL UPDATE
Vol. 2004 No. 2 March 2004

PHYSICIAN-HOSPITAL JOINT VENTURES - THE GOOD, THE BAD AND THE UGLY

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This article provides insight into the development and structure of physician-hospital joint ventures. Specifically, it comments on the common characteristics of successful and not successful physician hospital joint ventures. It also discusses the key business issues to be negotiated and certain of the key legal issues that have to be resolved.

I. CHARACTERISTICS OF SUCCESSFUL VENTURES

The following are some of the common characteristics of successful physician hospital joint ventures. First, the best ventures are formed where a hospital has a specific plan and desire to joint venture with its physician specialists, and is not doing so in response to physician threats or other demands. Rather, the hospital intends to be "pro-specialist" in its views of dealing with specialists and intends to manage its portfolio of business through alliances rather than by controlling specialist referrals through primary care physicians or insurance plans.

Second, as a corroraly to the first point, the joint venture is developed where the hospital is not brought into it kicking and dragging. Where a hospital is brought into a venture with negative perceptions up front, it often leads to a negative joint venture.

Third, the physicians perceive real value to the hospital being a partner. For example, the hospital has a strong community presence, generally a benevolent rather than negative presence, and perhaps a primary care base or managed care strengths. This may be particularly true where the hospital is in a Certificate of Need state or where the hospital has brought value to physician practices through assistance in managed care contracting or through other efforts.

Fourth, the hospital owns enough interests in the joint venture to remain interested but not to the extent that the physicians do not own enough to remain interested. For example, it used to be that physicians would view success in a negotiation by having the hospital own only 5 or 10% of the joint venture. However, history has shown that if the hospital does not own enough interest in the joint venture, it is likely to treat the joint venture as a strict competitor rather than as an alliance. Hence, a hospital typically needs to own 25 to 50% to perceive that it has real ownership interest in the venture. In contrast, if the hospital owns too much, there will not be enough shares left over for physicians, and the physicians will lose interest in the venture.

Fifth, in successful joint ventures, almost all of the decisions enjoy substantial consensus. Each party is able to give up a little control and live with the other party making certain decisions and follow that lead. In essence, the parties only fight over significant differences on the most major issues. Even there, consensus is often reached easily.

Sixth, the joint venture is built in close proximity to the hospital.

In joint ventures that do not work, there are certain flags that should be monitored. First, is it a situation where the parties have been forced together and one partner or another has a vision that a physician hospital venture is the right way to go. However, neither party is really that fond of each other and has chosen a joint venture for opportunistic business reasons rather than based on a strong relationship that leads to a joint venture plan.

A second situation is where the hospital owns too small an amount in the venture to have a significant interest. In contrast, too large of an interest may lead the physicians to resent the fact that most of the profits go to the hospital. A third situation to monitor is where the joint venture fails to make distributions and makes too much of an effort to reserve cash and capital. In certain situations, the hospitals' natural desire for cash distributions is not quite as high as that of the physicians. In some of these situations, cash has been accumulated for a new building project or to develop a new surgery center. Ultimately, most of the physicians lose interest in the venture and sooner or later start forming their own ventures. In the fourth situation, no third-party management company is involved. A third-party management company can often focus the parties on criteria and benchmarking and issues that need to be addressed in the venture. A third-party management company may also be able to take an objective view of the whole situation and keep the participants' eye on the ball. In contrast, where physicians and hospitals do not have a third-party manager, the focus is often taken off of managing and enhancing the venture and directed to the relationships between the parties. For example, if there are eight to ten issues to be addressed, and one of the issues relates to hospital competition with the venture, without a third-party manager, a great deal of the discussion could focus on this naturally incendiary issue. In reality, a real potential benefit to having a third-party management company is the ability to focus the parties on the other seven or eight issues where improvement can be readily had.

II. CORE BUSINESS NEGOTIATION DECISIONS

In forming a physician-hospital joint venture, there are four to six key provisions that need to be addressed. These include the following:

First, what will be the split of ownership? Generally, as with any joint venture, each physician, if possible, should own enough of a percentage to stay interested in the venture over time. A prescription for disaster is 30 physicians owning 1% each. In contrast, 20 to 30 physicians owning 2 to 3% each gives each physician a much greater stake in the venture. On the other side of the venture, the hospital should own enough to really want the venture to succeed and view it as a core part of its portfolio of businesses.

Second, the board of directors has to be agreed to. Here, the split of the board of directors should generally be based on a split of ownership. However, in certain situations, it may make sense to have a physician majority board but to provide the hospital with certain reserve and unilateral powers so it can assure that community benefits are served by the venture.

Third, a set of reserve powers have to be developed. These are veto powers that each side holds in the venture to assure that neither party acts too strongly and takes the venture in a different direction than planned.

Fourth, the parties will need to assess what type of charity care and level of community benefits the venture will provide. Although this is a hot button issue for many physicians, it is very unusual that the requirements to serve charity care and Medicare/Medicaid care actually have a negative impact on ventures. In fact, in

most ventures in which we are associated, we encourage the parties to proudly serve their fair share of indigent and Medicare/Medicaid patients, particularly on the outpatient surgery side. In most communities, the percentage of patients in this category will not have a negative impact on a joint venture.

Fifth, where a venture is already ongoing, and one party will invest in the venture - either the physicians investing in a hospital-owned venture or the hospital investing in a physician-established joint venture, a valuation will need to be obtained. Here, it is critical that the valuation reflect fair market value and for the transaction to be successful, that each party perceive that the valuation is fair and legitimate and was not "gamed" by either side, each party should approve of the valuation firm engaged so that there is a sense of trust in the development of the valuation. Many ventures falter simply because the valuation is not deemed to be legitimate or, if legitimate, provides for a purchase price that does not make sense for either the hospital component or the physician component.

III. CORE LEGAL ISSUES

The development or purchase into a joint venture should comply with two core legal statutes. First, if a hospital is an exempt hospital, the hospital desires that the venture be established such that it will: (1) not negatively impact the hospital's exempt status, and (2) allow the hospital to treat the income of the venture as exempt income. Of these two concerns, the first one, relative to loss of exempt status, is the nuclear concern. This is the type of concern that causes CEOs to lose their positions as CEOs. In contrast, the second concern regarding whether or not the income will be treated as exempt income, is a very flexible determination. For example, the worst case scenario here should generally be that the hospital has to pay taxes on income they receive from the venture. For a large system, even if a venture does not serve community benefits, it is extremely unlikely that the joint venture will have a negative impact on the hospital's exempt status as a whole. For example, it is commonly believed that a venture must reflect 10 to 15% of a hospital system's assets or revenues to negatively impact the exempt status of the entity as a whole. Here, the assets and revenues of the joint venture would be combined with other non-exempt activities of the hospital system to assess whether this 10 to 15% threshold is met. To avoid any potential that the venture will impact the exempt status of the hospital, it is common for hospitals to place the joint venture interest into an exempt subsidiary or a for-profit subsidiary.

Assuming that the loss of exempt status is not at issue, the next issue that the hospital faces is whether or not it can treat the income of the venture as exempt income. Here, it is critical that the hospital has sufficient power in the venture's organizational documents to assure that community purposes are met and that the documents reflect this need and, further, that the hospital actually takes actions on a regular basis to assure that the venture serves such purposes. While the actual language and efforts to meet these tests go beyond the scope of this article, we can provide additional articles at your request that discuss these issues in greater detail. For more information, please email Scott Becker at sbecker@mcguirewoods.com.

The parties, in addition to having to work through tax-exempt related issues, the parties must also establish the venture in compliance with the Medicare/Medicaid Anti-Kickback Fraud and Abuse Statute. Here, general rules include: 1) interests will only be sold to physicians who are outpatient surgeons or proceduralists; 2) share prices and other terms will not be differentiated based on the volume or value of referrals for a particular physician; 3) neither the venture nor any other investor to the venture may guarantee the investment or the loans or financing of the physicians to invest, nor will any party to the venture help the physician to finance his or her interest in the venture; 4) the venture and its participants will not discriminate against Medicare or Medicaid patients; 5) each physician will disclose his or her ownership interest to patients; 6) the hospital will not be brought into the venture as a reward for referring or driving patients to the venture; and 7) each party will pay fair market value for shares in the venture and the price will not be discounted in exchange for referrals that may be made by a physician or the hospital to the venture.

These reflect certain of the core Anti-Kickback Fraud and Abuse Statute prophylactic steps to be observed in establishing a physician-hospital joint venture. Again, we can provide a much lengthier article, *The Fraud and Abuse Statute and Investor-Owned Ambulatory Surgery Centers,* upon your request.

Should you have any questions about forming or developing a physician-hospital joint venture, please email sbecker@mcguirewoods.com or call Scott Becker at (312) 750-6016.

HOSPITAL CONFLICT OF INTEREST POLICIES/ ECONOMIC CREDENTIALING

Hospitals are increasingly implementing policies that limit the ability of physicians to maintain medical staff privileges at their facilities if the physicians have investment interests in ambulatory surgery centers or other hospitals that compete with the hospitals. These policies are often referred to as "economic credentialing". Physicians, hospitals and ambulatory surgery centers may challenge economic credentialing policies through political channels as well as through legal channels.

On the political front, the first step in challenging an economic credentialing policy which a hospital proposes is typically to develop a fairly pervasive campaign and plan. Here, a key goal is to engage the support of opponents to the proposed policy and to broadcast the potential illegality and negative consequences of the plan to many outlets. Engaging allies requires substantial efforts to "work" the phones. It also involves broadcasting the proposed policy to the various different parties who may be affected by the policy. An effort should also be made to ensure that several parties are opposing the policy and are galvanizing support to ensure that the hospital does not implement the policy. The effort should be widespread.

The second step in challenging a hospital's proposed economic credentialing policy involves the physicians and the other leadership contacting various associations and societies that can help to challenge the policy (e.g., state and county medical societies, specialty societies, etc.).

The third step involves developing a position paper that details the legal, ethical and practical pitfalls of the hospital's policy. Once the position paper is developed, the physicians and other leadership should distribute the paper to attempt to gain further consensus in their opposition to the policy. Here, the parties may also take one or more of the following actions.

1. Inform the State Department of Health and Department of Insurance of the hospital's proposed policy. Attempt to connect through contacts at such departments.

2. Deliver a letter to the board of trustees of the hospital that outlines the legal risks that the hospital may face if it implements the policy. Here, letters should come from two or more law firms representing different parties.

3. Consider identifying the appropriate hospital officer as the driving force behind the implementation of the policy. If a specified hospital officer is viewed as the driving force behind the policy, it may be easier to convince the hospital's board or the hospital officer to abandon the policy.

4. Obtain a consensus among the members of the medical staff to agree not to abide by the policy, and therefore, not to disclose any ownership interests that such members may have in competing facilities. One medical staff recently voted not to make disclosures. It may be difficult, however, to implement this approach. First, it may be difficult convince the medical staff

members to agree to such a plan. Second, state law may require physicians to disclose their ownership interests to patients who they refer to such facilities.

5. Consider having the medical staff take a vote against the policy. One may send a notification to the medical staff and circulate a petition protesting the policy.

6. Contact and ask for support from the American Medical Association, the state medical society, and any state specialty societies for their support in challenging the policy. This can be particularly effective with societies or associations that may also be affected by the policy.

7. Contact the National Federation of Independent Businesses or local allies.

8. Contact the chamber of commerce, the mayor, local congressmen, state representatives, and others.

9. Lead fund raising and political activities aimed at gaining support for opposition to economic credentialing policies and other anti-competitive behavior.

10. Provide the position paper to the State Attorney General, U.S. Attorney's Office, Department of Justice and Federal Sheriff Commission. Again, look for connections here.

11. Engage in a public relations campaign to demonstrate to the community how negatively the policy will affect the delivery of health care to the community.

12. Engage in dialogue with the hospital.

The goal is to prevent the implementation of the policy before it is approved by the hospital's board of trustees. It is much more difficult to convince a hospital to rescind this type of policy once it is implemented.

This type of policy may also be challenged on legal grounds. For example, if the policy is part of the medical staff bylaws, physicians may challenge the bylaws by following the procedures set forth in the bylaws and under state law. Alternatively, the policy may be challenged on the grounds that it violates state laws or federal antitrust laws. Any group of physicians or any healthcare facility challenging an economic credentialing policy should examine throughout the process the different procedural mechanisms to challenge the policy, including examining litigation approaches. Should you need assistance on these or any other issues, please call Scott Becker at (312) 750-6016.

SOURCE MEDICAL RAISES $7.5 MILLION IN INVESTMENT CAPITAL

Birmingham, Ala. / February 18, 2004 - *Source Medical*, the world's leading provider of outpatient information solutions, announced today that the company has raised $7.5 million in a round of private financing.

"We achieved record sales growth and generated over $31 million in revenue in 2003," said P. Daryl Brown, Source Medical's President and Chief Executive Officer. "Our investors have watched us grow from less than $10 million in revenue in 2001 to where we are today, and they are now even more committed to our ongoing success."

Source Medical's solutions enable healthcare providers to quickly and easily manage information about their patients using the latest computer technologies, dramatically reducing paperwork and errors associated with more traditional methods of medical documentation.

"Source Medical is committed to assisting our clients throughout every step of the patient care process, from scheduling and registration to clinical documentation to billing and collections," said Brown. "Our unique software solutions are proven to reduce healthcare costs, improve information accuracy and increase clinical efficiency."

With software products installed in 3,500 facilities nationwide, Source Medical is the leading provider of information solutions for physician practices, ambulatory surgery centers, surgical hospitals, rehabilitation therapy clinics and radiology facilities.

In a performance survey recently conducted by the Medical Group Management Association (MGMA), Source Medical was recognized as the number one software provider for ambulatory surgery centers, serving more customers than all other software providers combined, including McKesson, Medical Manager, Mysis Healthcare, Camberly Systems and VitalWorks, among others. Source Medical is also ranked among the top healthcare information technology companies in the nation by Healthcare Informatics magazine.

For more information, please visit www.sourcemed.net < http://www.sourcemed.net> or call 1-800-719-1904.