A SERIES OF UNFORTUNATE EVENTS:* Is This the End of the Physician/Hospital Joint Venture?

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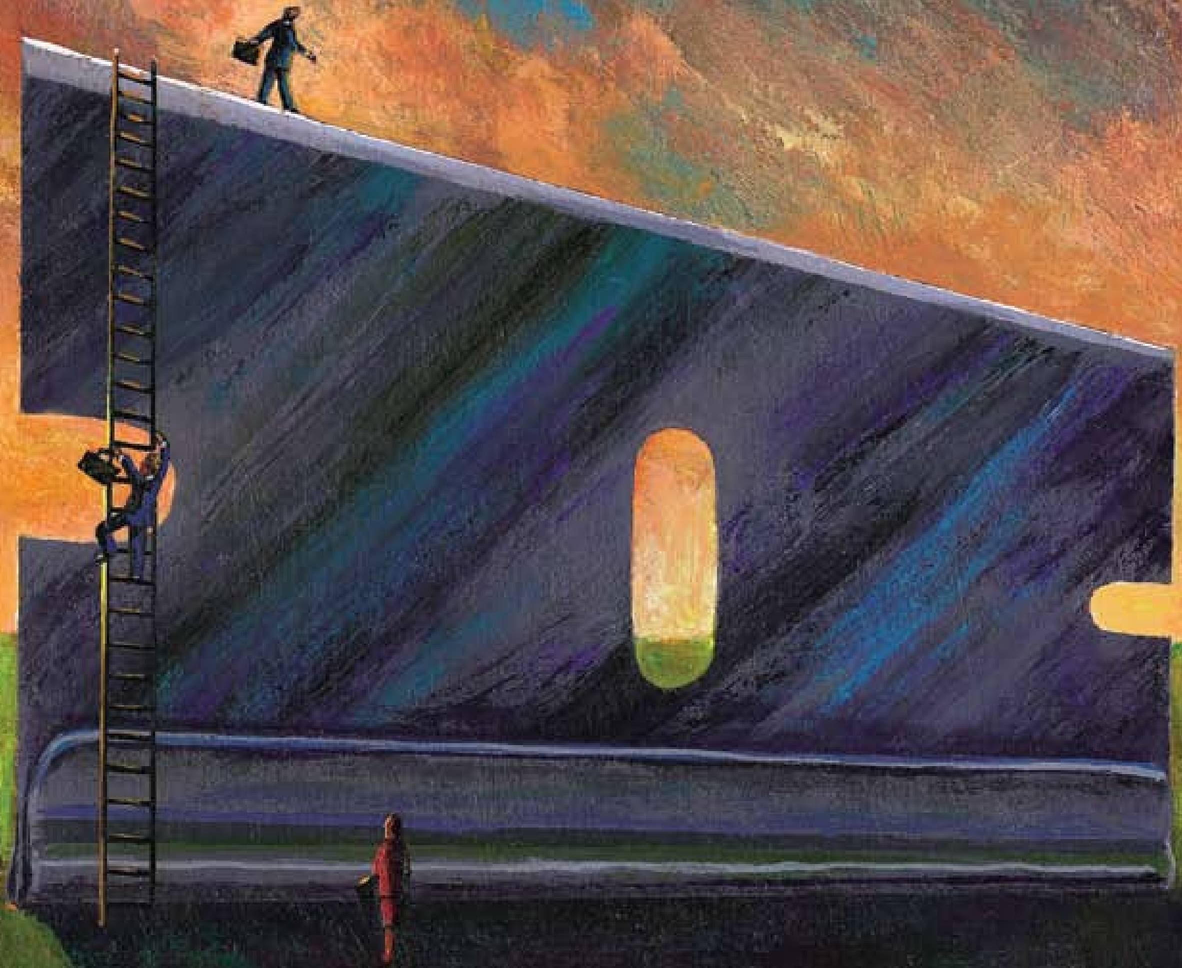

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I. Introduction

During the last several years, physician joint ventures of all kinds have come under increasing regulatory scrutiny, and the legitimate business purposes of physician/hospital joint ventures such as imaging centers, ambulatory surgical centers, cardiac catheterization laboratories, and hospitals have been challenged. The national credit crisis and the downturn in the overall economy also have put a damper on the willingness of hospitals and physicians to jointly invest and share the risks and rewards of new healthcare facilities and services. This article summarizes some of the regulatory pressures and the impact that they, and the collapse of the credit markets, are having on existing and future joint ventures. Although the future viability of the physician/hospital joint venture is by no means certain, there may still be opportunities for doctors and hospitals to collaborate.

II. Federal Regulation of Physician Joint Ventures

For the past twenty years, federal regulation of joint ventures involving physicians has fluctuated between uneasy tolerance and open hostility. In 1989, the Office of Inspector General (OIG) of the Department of Health and Human Services marked the beginning of this period by issuing a "Special Fraud Alert" (which was reprinted in the *Federal Register* in 1994) on "Joint Venture Arrangements."[1] In this Alert, the OIG described the arrangements that were causing it concern as follows:

> The Office of Inspector General has become aware of a proliferation of arrangements between those in a position to refer business, such as physicians, and those providing items or services for which Medicare or Medicaid pays . . . . Sometimes these deals are called "joint ventures." A joint venture may take a variety of forms: it may be a contractual arrangement between two or more parties to cooperate in providing services, or it may involve the creation of a new legal entity by the parties . . . to provide such services.[2]

The OIG's stated reason for questioning the validity of physician joint ventures was that "some of these joint ventures may violate the Medicare and Medicaid anti-kickback statute":[3]

> These subject joint ventures may be intended not so much to raise investment capital legitimately to start a business, but to lock up a stream of referrals from the physician investors and to compensate them indirectly for these referrals. Because physician investors can benefit financially from their referrals, unnecessary procedures and tests may be ordered or performed, resulting in unnecessary program expenditures.[4]

Nevertheless, the OIG did recognize that physician joint ventures could be formed in order to further genuine and lawful goals: "Of course, there may be legitimate reasons to form a joint venture, such as raising necessary investment capital."[5]

This pattern of alternating consternation and acquiescence over allowing physicians to benefit from their referrals through a joint venture entity has been evidenced in a line of OIG Advisory Opinions,[6] a Special Advisory Bulletin that was issued in 2003,[7] and a series of regulations issued pursuant to the federal Stark Law,[8] in which regulators have struggled to prevent the improper use of physician joint ventures while allowing legitimate joint ventures to exist.

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III. Impact of Recent Regulatory Changes on Physician Joint Ventures

Recently, the regulatory pendulum has swung to the "prohibition" end of its arc. A major revision to the Stark Law regulations that was implemented by the Centers for Medicare and Medicaid Services (CMS) as part of the final 2009 Hospital Inpatient Prospective Payment System will soon effectively prohibit "under arrangement" joint ventures between hospitals and physicians. Over the past few years, the "under arrangement" structure has become increasingly popular as a means for hospitals and physicians to co-invest in, and refer patients to, healthcare businesses such as cardiac catheterization labs and diagnostic imaging centers. The structure relies on provisions in the Stark Law regulations that define a "hospital" as *not* including "entities that perform services for hospital patients 'under arrangements' with the hospital,"[9] and that carve out from the definition of "ownership and investment interests" any "under arrangements

contract between a hospital and an entity owned by one or more physicians (or a group of physicians) providing [designated health services] 'under arrangements' with the hospital . . . ."[10] These definitions have allowed physicians to invest in joint ventures that provide "designated health services" (DHS) to hospital patients "under arrangement" and to refer patients to such joint ventures, without having to meet one of the Stark Law exceptions for ownership interests. Effective October 1, 2009, CMS revised the Stark Law's definition of "entity" to "clarify that a person or entity is considered to be 'furnishing' DHS if it is the person or entity that has performed the DHS (notwithstanding that another person or entity actually billed the services as DHS) or presented a claim for Medicare benefits for the DHS."[11] Under this new definition, an "under arrangement" joint venture entity will be considered to be "furnishing" DHS, since it is actually performing the DHS. Physician investors in the joint venture therefore will need to qualify for an exception to the Stark Law's prohibition on referrals in order to refer patients to the joint venture. In most cases this will be very difficult to accomplish, necessitating either the complete dissolution of the joint venture or a restructure of the joint venture into a legally compliant, but less profitable, form.

Other recent regulatory changes that have not been aimed directly at physician joint ventures have been, when considered together, almost as restrictive. For example, in issuing its 2008 Medicare Physician Fee Schedule, CMS extended the rule known as the "anti-markup rule" to cover not only the technical component of purchased diagnostic tests, but the professional component as well.[12] Prior to the change, the anti-markup rule prevented providers of diagnostic imaging services from purchasing the technical component of a diagnostic imaging service from a third party supplier and "marking up" the cost of the service when billing Medicare for the service, thereby profiting from the "markup." Explaining that "studies have shown that, in the aggregate, utilization of diagnostic tests increases in the case of physician self-referral,"[13] CMS announced that it was "also imposing an anti-markup provision on [the professional component] of diagnostic tests that are ordered by the billing physician . . . if the [professional component] is outright purchased or . . . is not performed in the office of the billing physician . . . ."[14] By extending the anti-markup rule to professional services, this change adds a new wrinkle to the structuring of diagnostic testing joint ventures by precluding them from profiting from the professional component of the diagnostic tests that they perform, where the physician or group that provides the professional component is doing so on an independent contractor basis and assigning to the joint venture its right to receive payment from Medicare.

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In addition to virtually banning "under arrangement" joint ventures, CMS' final 2009 Hospital Inpatient Prospective Payment System rulemaking revised the Stark Law regulations to impose new limits on the use of percentage-based compensation formulae and "per click" payments in lease arrangements that will make it more difficult to structure joint ventures that are both legal and financially worthwhile.[15]

Even proposed new regulations that are never finalized may have a chilling effect on physician joint ventures. In 2007, the U.S. House of Representatives approved legislation[16] that, if made law, would have significantly altered an exception to the Stark Law known as the "whole hospital exception." The "whole hospital exception" permits a physician to refer patients to a hospital in which the physician holds an ownership interest as long as the physician owns an interest in the "entire hospital and not merely in a distinct part or department of the hospital."[17] The changes would have precluded new physician investments in hospitals, thereby putting an end to a trend of increased physician investment in both general and specialty hospitals. Existing physician-owned hospitals would have been "grandfathered" under the new legislation, but would have been severely restricted in their ability to expand due to a ban on any increase in the number of their licensed beds.[18] Although the legislation was ultimately not enacted, these restrictions and the continued governmental focus on reducing or eliminating physician ownership of hospitals have likely made many entrepreneurial physicians extremely cautious about any plans to invest in new hospital joint ventures.

IV. The Credit Crisis—The Last Shoe to Drop on Joint Ventures

While the regulatory environment has made hospital/physician joint ventures financially challenging, the dramatic downturn in the economy and the subsequent tightening of commercial and consumer credit also has had a significant impact. As has been well documented in the national press, the collapse of the housing market due to the growth of subprime mortgages and the packaging of this type of credit by Wall Street has had far-reaching and unintended consequences well beyond the banking and real estate markets. Hospitals and physicians did not escape the negative impact of the national credit crisis.

During down markets hospitals typically have problems with liquidity, but the current situation is truly a "perfect storm." Most recessions bring high unemployment and increasing numbers of patients without insurance, resulting in an increase in bad debt. In addition, as hospital investment income is reduced, hospitals struggle to achieve profitability. However, this credit crisis has brought other surprises that have made access to cash even more difficult. For example, many nonprofit hospitals were surprised to learn that they owned auction rate securities that were not liquid and carried serious interest penalties. Auction rate securities were sold to hospitals as a cash alternative that could earn a low interest rate and could be easily converted to cash provided that the securities could be priced and sold at regularly scheduled auctions. Few, if any, hospital chief financial officers and investment advisors contemplated that the auction market would not exist, making cash investments illiquid and triggering certain interest rate penalties under these securities. To address this crisis of liquidity, many hospitals have found themselves refinancing, if possible, under very difficult terms or accepting significantly higher interest payments.

Compounding this difficult cash position is the continuing decline in the value of hospital endowments. As hospital balance sheets weaken, some facilities have had difficulty meeting their coverage ratios required under their tax-exempt bond financings. A number of financial rating agencies have described a negative outlook for the future for nonprofit hospitals.[19] Under these conditions, many hospitals will not be in a financial position to invest in new joint venture opportunities.

Similar to hospitals, physicians also are finding themselves in a weaker financial position as their practice income and the value of their investments decline. Many physicians historically have relied on joint venture transactions that have required small equity investments and a significant assumption of debt. Leveraged transactions have all but become extinct due to the difficulty in pricing debt and the resulting credit squeeze. Financing joint ventures, for the foreseeable future, will require a much higher proportion of equity at a time when both hospitals and physicians do not have the capital to invest.

V. Credit Issues: Making Regulatory Compliance Difficult

While new joint ventures may be "on hold," existing joint ventures will have their own problems complying with CMS regulations due to the credit market turmoil. Those ventures that have to dissolve their current businesses may find that their banks may not be very cooperative, especially if there is outstanding debt that must be repaid. Those ventures that will "morph" into another type of entity also may face the same difficulties with lenders. If the new venture structure requires a recapitaliza-

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tion, the parties may be unable to complete the transaction. For those entities that are unable to unwind without a financial disaster, there are other strategies to consider.

A. Sales to Third Parties: Roll-Ups Are Back!

Financially struggling healthcare ventures have several choices to consider if they cannot unwind. First, they could sell their joint venture to a third party. For some imaging centers and ambulatory centers, there are a number of for-profit companies seeking to purchase healthcare assets as part of an existing "roll-up" strategy. In addition, some private equity funds invest exclusively in distressed assets and have targeted healthcare as a potential investment opportunity. These acquisition strategies may seem contrary to the decline in the overall economy, but operating companies and private equity funds with cash thrive in down markets. During the next several quarters, these entities will be looking for buying opportunities. Hospital systems and their physician joint venturers could benefit from the sale of struggling joint ventures to operating companies by taking back cash or stock in the transaction. While valuations have plummeted in some cases, there are still buyers willing to pay a reasonable valuation for an enterprise with some cash flow.

B. Restructuring Debt . . . If You Can

Second, some ventures have considered negotiating with lenders to restructure their relationship as the venture unwinds. Smaller local banks have often been supportive of these new ventures and have been willing to find innovative ways to restructure existing debt. The importance of the hospital and/or the physicians as customers of the bank and the financial condition of the bank will determine how flexible the bank can be in helping to fund the new venture. While painful to hospitals and physicians, restructuring debt is becoming a common occurrence and a good way to breathe new life into an organization with limited options.

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C. Business Reorganization: It May Be the Only Option

Finally, some joint ventures will have to consider a reorganization strategy that involves a bankruptcy filing. There have been a number of imaging centers and ambulatory surgery centers that have had to consider these distressed strategies due to declining reimbursement and increased competition. There is also a belief among investment analysts that there will be a continuing increase in the number of hospital bankruptcies due to their declining financial condition.

VI. New Opportunities for Hospitals and Physicians

Most of the current joint ventures between hospitals and physicians were entered into for several reasons: Hospitals were looking for ways to strengthen the relationship between a group of doctors and the hospital, and to reduce competition for patients for a specific service. Doctors also were attempting to reduce competition, as well as to share the cost and the risk of a new enterprise. Of course, all of the investors also were motivated by the potential to earn a profit. However, few joint ventures contemplated an exit strategy to maximize the enterprise value of the joint venture, or the proverbial investment banking "liquidity event." In a "down" market, what types of collaborative transactions can physicians and hospitals undertake given the current regulatory environment?

A. Co-Investment Opportunities with Hospital Private Equity Funds

Some new opportunities are being undertaken that may provide some insights into future joint venture relationships. One of the key areas for hospital and physician collaboration could be healthcare-related investments. Some large hospital systems have developed their own private equity funds that invest in start-up healthcare companies as well as companies that are seeking capital investment to support growth. These hospital private equity funds could be open to physician investment as another way to more closely align the physicians' and the hospitals' interests. While risk-averse hospitals and physicians would argue against such a strategy given the economic conditions, for some entrepreneurial hospitals and doctors such investments could provide real opportunities to share risk and reward.

B. Leveraging Hospital and Physician Resources with Start-Up Businesses

Most hospitals and physicians will not have the capital to invest in a fund or create their own fund. Hospitals have used their resources

and have made in-kind contributions to start up ventures. For example, in exchange for stock in a new company, a hospital and key physicians may offer their technical expertise to the start-up. Such technical expertise may include using the hospital as a "beta site" for use of a new device, software, or product. Physician input also is valuable especially for medical devices and some software applications. The overall strategy in these approaches is to find a way for hospitals to collaborate with physicians and to leverage the resources that they can offer to a start-up company in exchange for stock, thereby eliminating the need for them to make a cash investment.

C. Private Equity Partnerships

Neither hospitals nor physicians have traditionally collaborated with private equity investors on a formal basis. In fact, many private equity funds have significant informal relationships with hospitals and physicians to "pick their brains" about certain investments the fund is considering. Private equity firms are looking at the healthcare industry as one of the growth areas in the economy. Instead of continuing an informal process, hospitals and physicians should consider formalizing the relationships with private equity funds in the same manner as described above with respect to start-up businesses.

VII. Some Final Thoughts

The future for hospital/physician joint ventures is uncertain at best. It would not be surprising if most hospitals and physicians "sit on the sidelines" until there are clear signals that the financial and regulatory environment for joint ventures is more secure. However, there are always those who will find opportunity amidst the current confusion. Hospitals and physicians will need to find new ways to create long-term enterprise value, not short-term cash value, by using their collective resources as the currency to obtain ownership in new ventures.

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* Apologies to Lemony Snicket.

1 59 Fed. Reg. 65372 (1994).

2 *Id.* at 65373.

3 *Id.* The federal anti-kickback statute prohibits the offering, payment, solicitation or receipt of remuneration (including any kickback, bribe or rebate), directly or indirectly, overtly or covertly, in cash or in kind, for (i) the referral of patients or arranging for the referral of patients to receive services for which payment may be made in whole or in part under a federal or state healthcare program, or (ii) the purchase, lease, order, or arranging for the purchase, lease or order of any good, facility, service, or item for which payment may be made under a federal healthcare program. 42 U.S.C. § 1320a-7b.

4 59 Fed. Reg. at 65374.

5 *Id.* at 65373.

6 *See, e.g.,* OIG Advisory Opinion 98-12 (Sept. 16, 1998) (ambulatory surgery center joint venture among orthopedic surgeons and anesthesiologists); OIG Advisory Opinion 04-17 (Dec. 10, 2004) (pathology services joint venture between pathology laboratory company and physician group practices); OIG Advisory Opinion 08-10 (Aug. 19, 2008) (block lease arrangements between oncology group practice and urologists).

7 68 Fed. Reg. 23148 (2003).

8 *See* 66 Fed. Reg. 856 (2001); 69 Fed. Reg. 16054 (2004); 72 Fed. Reg. 51012, (2007). The Stark Law prohibits physicians who have a "financial relationship" with an entity from referring Medicare or Medicaid patients to that entity for one or more "designated health services" unless one of several limited exceptions applies. Under the Stark Law, a "financial relationship" exists if the physician or an immediate family member has a direct or indirect ownership or investment interest in, or compensation arrangement with, the entity providing designated health services. 42 U.S.C. § 1395nn.

9 42 C.F.R. § 411.351.

10 42 C.F.R. § 411.354(b)(3)(iv).

11 73 Fed. Reg. 48713 (2008).

12 72 Fed. Reg. 66306 (2007).

13 *Id.* at 66313.

14 *Id.* at 66308.

15 73 Fed. Reg. at 48713.

16 H.R. 3162, § 651.

17 42 C.F.R. § 411.356(c)(3)(iii).

18 H.R. 3162, § 651.

19 For example, on December 2, 2008, Fitch Ratings issued a press release stating that it had "revised its Outlook on the U.S. not-for-profit hospital sector to Negative from Stable."