

The BEST of Times and the The WORST 2009 of Times

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Hospitals and health systems, whether general acute care hospitals or specialty hospitals, are attempting to prosper in a challenging time. Last year and in 2007, the nation's hospitals, as a whole, recorded record profits. Many hospitals were examining a multitude of options for debt financing. Nearly 20% or more of the nation's hospitals were in the process of renovating, expanding or replacing their current hospitals.

As of 2009, the freezing of the financial markets, the loss of the value in hospital and related foundation portfolios, the underfunding of pension obligations, the movement in a negative direction of payor mix, and the delaying of procedures are greatly changing the financial situation for hospitals. While the country's 1,000 healthiest hospitals remain healthy, this remains a time of tremendous uncertainty and risk in the hospital industry. This article discusses five strategic and development issues facing hospitals:

1. THE JOINT VENTURING OF SERVICE LINES.

Joint ventures can provide substantial

benefits to hospitals. There are also severe limitations involved in the use of joint ventures.

First, in terms of benefits to a hospital, a joint venture provides a means to develop congruent relationships with physicians. When both the hospital and the physicians have vested interests in a venture, it places the parties on the same page; both parties work together to control costs and achieve a profitable venture. It also avoids an employer-employee or boss-servant type of relationship.

Moreover, joint ventures are often less expensive alternatives for hospitals to pursue. Primary alternatives in the past have included, for example, attempting to control patient flow by employing significant numbers of primary care physicians and specialists. It has clearly proven expensive to employ and main-



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tain a primary care owned network. It is also proving difficult to maintain productive specialists as employees of hospitals or health systems.

Another key benefit to joint ventures is that a joint venture allows for greater freedom for both the hospital and the physician than the traditional employer-employee relationship allows. For example, in a typical joint venture, a majority of physicians maintain an independent practice outside of the joint venture. This type of arrangement allows for congruency in the joint venture between the hospital and physician, yet offers the physician a certain amount of freedom outside the joint venture.

There are also challenges and limitations to the use of joint ventures. For example, due to a number of business and regulatory issues, once a hospital invests in a joint venture it is often difficult to modify the partners or terminate the joint venture without suffering substantial damages or losses.

Second, in certain types of joint ventures, hospitals receive lower reimbursement if they choose to enter into a joint venture with physicians than they would otherwise. For example, hospitals receive lower reimbursement if they choose to joint venture an ambulatory surgery center with their physicians as opposed to simply receiving hospital-based reimbursement for an

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outpatient department. Thus, in addition to splitting the profits of the joint venture with the physicians, the venture as a whole will receive lower reimbursement than if operating as a unit owned solely by the hospital.

Third, true joint ventures are not permitted in certain specialties for certain types of services. For example, it is difficult to joint venture various imaging modalities with physicians who are not radiologists. The Stark Act, which prohibits physicians from referring to an entity with which they have a financial relationship, classifies radiology and other imaging services as “designated health services.”¹ A financial relationship is defined as any investment, ownership, or compensation relationship. Therefore, subject to a rural exception, a non-radiologist physician owner (for example, an orthopedist, a primary care physician, or a neurosurgeon) may not invest in a joint venture and generally may only “own” and provide imaging services pursuant to the in-office ancillary services exception which is a restrictive exception.² In addition, states are beginning to limit ownership in imaging by non-radiologists as well. The Maryland Attorney General interpreted the state physician self-referral bill, which is similar to the Stark Act, to specifically exclude magnetic resonance imaging services, radiation therapy services, and computer tomography scan services from the in-office ancillary exception.³ The Centers for Medicare and Medicaid Services (CMS) has expanded the list of Stark services to include nuclear medicine and positron emission tomography services. This would further limit the ability to enter into joint ventures for such services. There is also increasing scrutiny of imaging ventures set up as quasi-joint ventures as recently highlighted in national newspapers.⁴

Fourth, a joint venture strategy is limited to certain physician specialists and is difficult to utilize for an entire medical staff.

For example, the benefit of a joint venture – congruency between the hospital and physicians, controlled costs, vested interest in profits – becomes too diluted if too many physicians are involved in the joint venture. In short, a joint venture is useful to none if everyone is involved. This means that where a medical staff includes two to three hundred physicians, a joint venture may ultimately be a useful option for a small minority of the whole staff.

The role of joint ventures is likely to continue to evolve over the next three to five years. In general, joint ventures can be expected to proliferate for smaller types of service lines and services facilities,

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ties, including ambulatory surgery centers, cardiac catheterization facilities, and imaging facilities, among a handful of other types of service lines and facilities. In contrast, joint venturing of many large scale projects is not expected. In essence, the development of joint venture specialty hospitals between hospitals and physicians is expected to some degree, and a smaller number of joint ventures of acute care general hospitals are expected between hospitals and physicians.

2. LANDMINES FACING HOSPITALS.

Many of the key problems that hospitals may face in the near future have not yet

surfaced in part because hospitals are currently experiencing a favorable revenue and business cycle. This favorable business cycle has left many hospital systems insufficiently prepared for dips or downturns in the revenue and reimbursement cycle. Large national payors are pushing back with respect to climbing reimbursement and pricing. On a national level, there is discussion regarding the need to cut back or to reign in Medicare costs and the amounts paid to hospitals. If possible, the government may attempt to limit costs by decreasing reimbursement in niche areas where there is not as much political strength. Hospitals still must be prepared for changes in the revenue cycle.

There are four specific concerns.

Hospitals have overleveraged themselves. This reflects several different characteristics. On one hand, hospitals remain confident in development plans and are regularly expanding and renovating hospitals to capture or maintain certain types of service lines and revenues. Overall health care construction and commitments to construct increased dramatically from 2004 to 2008. Other entities are investing in information technology while others are pursuing deals to merge. On the other hand, however, most hospitals, as not-for-profit, tax-exempt entities, are not forced to make distributions to shareholders. Because hospitals do not have to account to shareholders in that manner, it is easier to find opportunities to invest money in new programs and buildings, rather than prepare for the future by disciplined saving or re-payment of loans.

Second, a number of the nation’s hospitals do not appear prepared for reductions and changes in reimbursement. Many hospitals have benefited from increased Medicare reimbursement and a lack of payor discipline over the last few years. Payors are returning to the zero sum game approach to negotiation

efforts with hospitals. The health insurance industry is in a consolidation mode. This generally leads to greater power for the surviving payors and less negotiation leverage for providers. As noted above, all hospitals must be prepared for a slow down in Medicare reimbursement increases and potential reductions in payments from other payors.

Third, many hospitals do not maintain sufficient reserves. Hospital margins are relatively narrow. According to a Med-Pac report, there has been a decrease in hospital total margins. Total margin was measured by inclusion of all patient care services funded by payors, plus nonpatient revenues. In the aggregate, hospitals saw total margins decrease from 4.4% in 1991 to 3.4% in 2000. Given the small margins, insufficient reserves to cover losses can be problematic when a hospital faces a downturn in the revenue cycle.⁵ Many hospitals in this regard are facing large unfunded pension deficits.

Fourth, a number of hospitals consistently chase the "next big thing." The "next big thing," a few years ago was an expensive cardiac program. In many situations, the open heart programs proved to be less profitable than expected. This is, in large part, due to improvements in technology and decreases in the number of open heart surgeries performed. Currently, many hospitals are aggressively investing in different types of cancer treatment technologies and new types of buildings and development related to orthopedics and spine. However, if the number of admissions and procedures does not meet expectations, or if reimbursement stagnates or decreases, chasing "the next big thing" may lead to situations where the results for certain programs sorely miss expectations.

3. FINANCING VEHICLES.

Very healthy hospitals still face a plethora of options as to how to finance their investments in facilities and programs. For hospitals in good financial shape,

the choice of lenders, from traditional commercial banks to private equity driven financing companies to publicly traded entities focusing on commercial and health care finance, is still significant. For a typical project, real estate or equipment driven, a hospital may choose to structure the project through either fixed or variable rate financing options, options not always available in the past. These options often involve captive finance programs from the vendors themselves who may include large equipment companies or real estate entities or middle market lenders that focus on loans ranging from \$10 to \$150 million.

Certain of these new types of financing choices are intended to improve hospital/physician relationships. For example, the use of participating bonds allows physicians and local community members to hold a part of the debt used by a hospital or a hospital project. It may also include, as noted earlier, the use of joint venture projects which enable participating physicians to share in the capital needs of a venture. In these situations, the cost of these alternative sources of capital can be high in terms of the transaction efforts and fees. At the same time, these options offer a tangible benefit by helping to solidify relationships between physicians and hospitals. Accordingly, hospitals will often utilize a joint venture approach to financing projects even if it may be more expensive in terms of transaction costs and other types of challenges than doing the project alone. Participating bonds are used less often as the transaction costs for such products have proven to be so expensive that many hospitals choose not to use participating bonds unless the project is of such size and scope that the cost will be relatively reasonable in comparison to the total amount being raised. Over the next few years, financing options are expected to continue to proliferate until hospitals, once again, are faced with

challenges relating to the financial performance of projects.

The number of the nation's hospitals that are not in strong or even good financial shape has increased significantly in the last twelve months. Whether these hospitals are semi-rural or located in difficult urban environments, these entities face a very significant increased struggle to find financing on any level. Often when financing is available, it is available only at high rates and can be developed only to the extent that there are tangible assets available to serve as collateral for the financing. In contrast, healthy hospital systems can utilize their traditional cash flows and projected cash flows to help obtain financing.

4. HOSPITAL STRATEGY FOR THE NEXT FEW YEARS.

Hospital planning over the next few years should be driven by three conceptual strategic approaches – an offensive approach, a defensive approach and an allocation method or approach. First, hospitals must play offense. This means constantly seeking new revenue lines. These can be "home run" profit lines, such as the efforts by many hospitals to develop oncology programs or leadership in orthopedics or spine. In contrast, investing smaller amounts in a number of service lines as a way to increase profits and revenues has also benefited hospitals. This may include simply reinvesting in the three to five key programs the hospital sees as its most profitable or to add a few service lines.

Second, hospitals must aggressively play defense. This means not over-leveraging the hospital through excessive debt financing or overstaffing of certain programs. It also means preventing erosion of the hospital's revenue base by aggressively challenging or preempting joint venture efforts and market encroachment efforts by other hospitals and health systems.

Finally, hospitals must adopt the concept of allocation as an overriding strategy. Too often, hospitals are significantly over invested in one service line or one service category. Over the last few years, hospitals that have over invested in certain types of service lines, such as surgical, imaging, oncology, orthopaedic or neurosurgical, have performed very well. However, hospitals are better off allocating their risk by investing in several different service lines. In addition, hospitals must develop a service line or a specialty where they can become known and recognized as a key provider in their community, and become the distinct provider of choice. In essence, they must develop some specific reason for existence as revenue lines change and competition unfolds.

5. LEGAL ISSUES, CONGRESSIONAL ATTACK AND CLASS ACTION SUITS.

Not-for-profit hospitals are facing distinct attacks on several different levels. First, Congress has opened up an investigation as to whether hospitals are actually doing enough to earn and maintain their tax exempt status. The Senate Finance Committee has delivered extensive questionnaires to ten tax-exempt hospitals and health systems, seeking details on activities ranging from travel to compensation to charity care.⁶ In addition, the House of Representatives Ways and Means Committee has held a series of public hearings focusing on the tax-exempt sector, with particular focus on the not-for-profit, tax-exempt hospital.⁷ Second, many states and local communities are making efforts to try to reduce or erode tax exemption.

In the long run it is expected that Congress will take little, if any, action to fundamentally change the way not-for-profit hospitals do business. As a business reality, not-for-profit hospitals are a huge employer in many places, and are vital to many communities. For example, in 2008, tax-exempt hospitals and health care

organizations controlled approximately \$490 billion in assets and received over \$500 billion in gross receipts.⁸ Further, the debt markets are extremely important to the national economy and provide great investment opportunities for a whole variety of participants. A challenge to the status of the tax-exempt entities that would result in a reduction of the supply of tax-exempt investments would have a substantial impact throughout the country. While Congressmen may enjoy the investigative aspects of the effort to examine the not-for-profit sector, any changes in tax exempt finance laws and how exempt hospitals function would have draconian and unexpected results throughout the health care economy and the national economy as a whole. It is expected, at some point, that politicians will use these types of investigations as a cover to wrestle with real and legitimate cost concerns of the Medicare program. In essence, certain of the negative aspects that come out of the Congressional investigations as to the tax-exempt sector may be used as tools and tactics to provide political cover and to ultimately reduce reimbursement to hospitals and health systems.

On the state side, there will continue to be state-to-state skirmishes over issues related to the state tax and local tax exemption. This is particularly true in small communities where the hospital has evolved into one of the biggest employers, if not the biggest employer, and particularly if the community has lost some of its tax paying businesses. For example, the Illinois Department of Revenue revoked the local property tax exemption for Provena Covenant Medical Center (Provena) in Urbana, Illinois following a determination by the local tax board that Provena was not a charitable institution because of the way it treated needy patients.⁹ In essence, the manufacturing decreases in many communities and as the taxes are paid by such companies decrease as well, there

will be more pressure on local communities to attempt to reap some tax benefits from their local hospitals.

This analysis examines five different issues that are facing hospitals and health systems throughout the country. If you would like further information on any of these issues, please contact Scott Becker at (312) 750-6016 or by email at sbecker@mcguirewoods.com or Elissa Moore at (704) 343-2218 or by email at emoore@mcguirewoods.com.

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During the past several years, Mr. Becker has devoted a substantial majority of his time and efforts related to ambulatory surgery centers and to hospitals and health systems. His efforts have included structuring ambulatory surgery center joint ventures; providing legal opinions regarding the 501(c)(3), fraud and abuse statute, self referral and Stark implications of surgery center business and physician relationships; drafting and implementing private placements and joint ventures of surgical centers; procuring Certificate of Need determinations; reviewing reimbursement related issues; reviewing antitrust issues; negotiating business contracts; drafting and implementing compliance plans; negotiating private equity investments; and providing advice and counsel on a broad range of business and legal issues. He also has worked with magnetic resonance and other imaging facilities, as well as with cardiac catheterization facilities.

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¹ 42 U.S.C. § 1395nn.

² 42 C.F.R. § 411.355(b). In order to satisfy the in-office services exception, a physician has to meet separate supervision, location and billing tests, each of which focus on whether such services are truly ancillary to the medical services being provided by the physician or group practice.

³ Md. Code Ann., Health Occ. § 1-301(k)(1) (2005). On January 5, 2004, the Maryland Attorney General released a legal opinion stating that the law bars a non-radiologist physician from referring patients for tests on MRI machines or CT scanners owned by the physician or his or her practice. 89 Op. Att'y. 10 (Jan. 5, 2004).

⁴ Armstrong, David, *MRI and CT Centers Offer Doctors Way to Profit on Scans*, Wall Street Journal, May 2, 2005.

⁵ MedPac, "Data Book on Hospital Financial Performance," Appendix D. Table D-15 shows a decreasing trend in hospital total margins. Over the same time frame, urban hospitals saw a decrease in total margins from 4.3% to 3.3% while rural hospitals saw a decrease in total margins from 5.2% to 4.4%.

⁶ See <http://finance.senate.gov/press/Gpress/2005/prg052505.pdf>, for the press release and full text of the detailed questionnaire.

⁷ See <http://waysandmeans.house.gov/Hearings.asp?congress=17>, for transcripts of the public hearings relating to the tax-exempt sector and hospitals.

⁸ Testimony of the Honorable Mark Everson, Commissioner, Internal Revenue Service, before the House Committee on Ways and Means, May 26, 2005.

⁹ The Champaign County Board of Review, responsible for property-tax assessments, argued that the hospital filed lawsuits and used aggressive debt-collection tactics against patients who didn't pay their bills. As a result of the decision, Provena had to pay \$1 million in property taxes. Provena is currently appealing the decision of the Board of Review to the Illinois Department of Revenue.