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Cardiovascular Joint Ventures

How Physician-Hospital Economic Partnerships Can Improve Quality, Control Costs & Increase Profitability

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Introduction

Recent national headlines indicate that Americans are spending more than ever for healthcare, and cardiovascular care is one of the biggest ticket items. As a result, despite tremendous provider-driven advances in recent years in terms of saving lives and lowering cardiovascular death rates, government agencies and major payors are focusing a spotlight on provider utilization patterns and financial practices. In addition, an increasing number of academic studies are questioning whether the current level of spending represents a sound investment. It has been convincingly demonstrated that per capita spending on cardiovascular care varies dramatically around the country without any apparent logic—or more importantly—without any discernable correlation with improved health.

Cardiovascular care is a natural target for economic joint ventures because cardiovascular physicians and hospitals absolutely need each other to do their work.

But many hospitals and cardiovascular physician practices around the country are combining forces to address these issues. And a key weapon in their arsenal is a standard business tool with useful applications in almost all industries—the economic joint venture. Cardiovascular care is a natural target for developing joint ventures because, unlike some other medical specialties, hospitals and cardiologists absolutely need each other to do their work. Despite the increasing shift to outpatient care seen nationally, much of cardiovascular care remains inpatient in nature. The principal problem is that the various interests of hospitals and cardiovascular physicians are rarely aligned, resulting in the random patterns in utilization and outcomes that researchers have documented. But much of this can be overcome through the structuring of formal business and clinical partnerships.

Pure demographics and technological advances dictate that there will be tremendous future growth in cardiovascular care. Yet now more than ever providers of cardiovascular care need to demonstrate that their actions dramatically improve the health of their patients and actually save the country money in terms of increased worker productivity and quality of life. There are many opportunities for hospitals and physicians to use joint ventures to make this happen. In this paper we have chosen to highlight a variety of structures—some of them time-tested, others cutting edge—with the potential to bring about alignment of hospital and physician interests. While certainly not

exhaustive, this information will serve as a good point of departure for cardiovascular leaders in evaluating their need to respond in a practical way to the clinical and financial challenges they face.

Defining The Terms

When speaking of joint ventures it is crucial to clearly define the terms involved. Failure to do so, we have found, can result in the destruction of the communication channels and relationships that are essential to any joint venture's success. While the phrase 'joint venture' occurs with some frequency in physician and hospital planning sessions, there is rarely a commonly understood baseline definition. It means different things to different people. We have observed some hospital administrators, for example, express the belief that a joint venture is simply an arrangement under which a hospital gives money to physicians. This would be funny—if the potential legal consequences of such a viewpoint weren't so serious. Because of the legalities governing joint ventures in healthcare, the most useful definitions come from official government sources. But even here things are rarely cut and dried. For example, the Office of Inspector General (OIG) has recently defined joint ventures in healthcare as "any common enterprise with mutual economic benefit.[1]" This definition seems too broad to provide any real guidance. However, in a landmark OIG publication in 1994, a more specific definition was used: "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, such as a limited partnership or closely held corporation, to provide such services.[2]" For the purposes of this paper we are adopting a version of this definition. In order to qualify as a cardiovascular joint venture, any arrangement between physicians and hospitals needs to satisfy the following three criteria:

A cardiovascular joint venture is a contractual arrangement between two or more parties to cooperate in providing services, or the creation of a new legal entity to provide such services.

1. The arrangement needs to be established contractually;
2. It needs to involve the provision of healthcare services; and,
3. Each participant must bear some risk in return for a possible reward.

Further analysis of the relevant legal and financial considerations surrounding cardiovascular joint ventures are found in later sections of this paper.

The Quality Gap

There are an almost infinite number of reasons that might be suggested for pursuing joint ventures. Most of them are unimportant. Amongst all the possibilities, there is really only one that matters: can a joint venture be used to increase the quality and cost effectiveness of care delivery? If this question can be answered in

the affirmative, then all efforts should be made to craft the relationships and structures necessary to realize these benefits. Of course, any argument in favor of improving quality and controlling costs carries the implicit assumption that there are significant cost and quality problems in our healthcare system. And indeed this is the case. Many studies have documented wide variations in use rates and high errors rates in hospital care. Interestingly, these studies rarely find any correlation between the cost of care and its outcomes. Specific to cardiovascular care, one recent study concluded that "Regions with higher expenditure indices did not provide better quality of care on most measures. Among patients in whom the specific treatment was recommended, patients with acute MI in the highest quintile were no more likely to receive acute reperfusion, were less likely to receive aspirin at admission or discharge and ACE inhibitors in the setting of a low ejection fraction, and were more likely to receive beta-blockers.[3]" This imbalance—and the myriad others that have been documented—is disturbing; but it doesn't have to be this way. In fact, some cardiovascular programs produce much better results. These results have been documented and published in a number of venues. For example, Solucient (a healthcare data company) conducts a periodic study of cardiovascular programs for use in its annual *Top 100* ranking publications. The most recent version of this study produced findings typical of years past. If all hospitals in the study performed at the level of Solucient's *Cardiovascular Benchmarks for Success* the following conditions would prevail:

- Deaths from cardiovascular surgery in the U.S. would drop drastically—mortality rates would decrease nearly 15 percent for both angioplasties and bypass surgeries. Post-operative mortality rates would drop 18 percent.
- The death rate would drop for cardiac patients not requiring invasive procedures as well: 9 percent for heart attack patients.
- Patient complications would also decrease: infections after surgery would plummet 26 percent, and post-procedural hemorrhage would fall 21 percent.
- Lengths of stay for cardiac patients would fall by an average of half a day and costs would drop by $250 million—an average of $415,000 per hospital[4].

So what is the primary obstacle preventing more hospitals from achieving this nirvana in which outcomes are better and costs are lower? Our candidate is the fundamental disconnect between the interests of hospitals and physicians. Hospital systems are different from many other industries in that they are both labor and capital intensive. Yet while the resource demands are high, there is only a very limited set of tools that hospital administrators have at their disposal to control expenditures. Most of this power actually lies in physicians' hands. It has been remarked that the most expensive medical device in the world is a physician's pen. By this it is meant that most healthcare spending results from a physician's orders. Whether writing a prescription, ordering a diagnostic test, or admitting a patient to a hospital—it

The primary obstacle preventing more hospitals from achieving better outcomes and lower costs is the fundamental disconnect between the interests of hospitals and physicians.

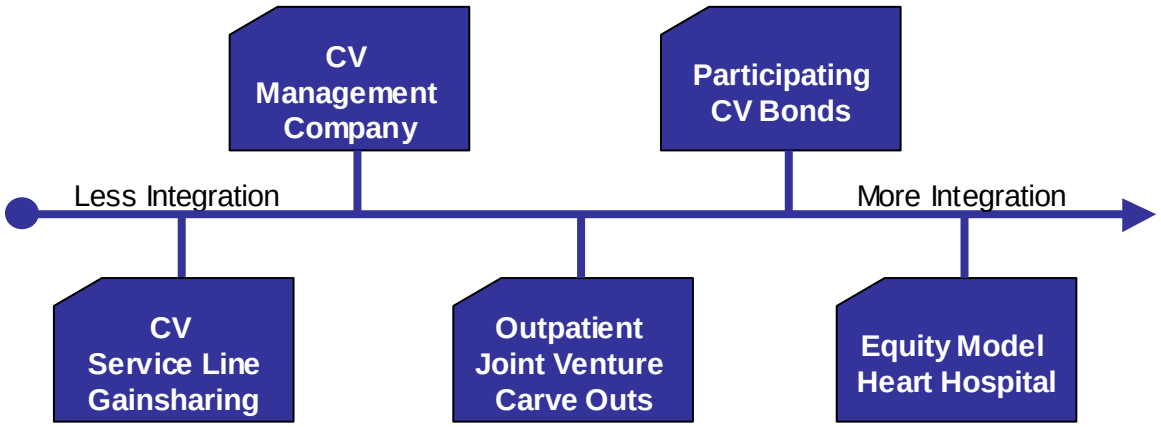
all originates with physicians' orders. And hospital administrators, charged with coordinating and fronting the cost for much of this care, are essentially powerless to meaningfully influence this process. This is nowhere more true than in cardiovascular care. It has been estimated that physicians are responsible for the clinical decisions that result in up to 70% of the direct cost of cardiovascular care[5]. This disconnect results in inefficiency and waste when it is not recognized and confronted by all parties. It is the distance between what is *known* from research about how to produce stellar clinical and financial outcomes, and the actual *practices* of poorly designed care delivery systems that results in the quality gap. While many theoretical approaches to reforming these systematic deficiencies exist, actual implementation has lagged behind. As massive financial pressures in healthcare mount, we expect cardiovascular leaders to take a fresh look at different program structures. It has been our experience that the best prospects for the lasting alignment of the interests of physicians and hospitals lie in the structuring of formal economic joint ventures for the provision of cardiovascular services.

Catalysts for Change – Cardiovascular Joint Ventures

Not all economic partnership models are created equal. Different models offer different benefits, and sometimes these benefits are achieved in a tradeoff with other considerations. Because there is no one-size-fits-all approach to something as complex as a cardiovascular care delivery system, we consider here a variety of models. While certainly not exhaustive, each of the following models achieves a different balance in terms of the degree of integration that is sought and the amount of autonomy that is retained. They are represented as if they were part of a continuum (see Figure 1) because as a practical matter hospitals and physicians often start with smaller scale projects with more modest aims, and eventually proceed with plans to increase the size and scope of smaller ventures that prove successful.

1. **CV Gainsharing.** The basic premise behind cardiovascular gainsharing is sound: involve physicians in controlling service line costs and let them keep a portion of the savings. Under this type of model, for example, if the results of a concerted effort to standardize cath lab supplies and streamline treatment protocols resulted in $1 million in savings over the previous year's results, then the participating physicians could receive a negotiated percentage of this amount. While this may be a useful approach to motivate more rational resource utilization, it can also set the stage for potential conflicts: How is a hospital's not-for-profit status impacted by this type of contract with a for-profit medical practice? Might this approach cut too deeply and constrain the delivery of necessary care? Could gainsharing be considered a kickback in violation of federal statutes? Yet while these are truly thorny issues, they are not unsolvable. And there are currently a number of cardiovascular programs operating such programs, and at least one with the knowledge and apparent blessing of the OIG; currently, many more such proposals are also under consideration. In our view, however, the primary limitation of gainsharing arrangements is neither a legal nor ethical concern. The primary limitation is the

Figure 1 - Cardiovascular Services Continuum of Integration Between Hospitals and Physicians



limited timeframe under which the promised benefits can be achieved. In practice, the cost baseline for a gainsharing program must be re-set each year, which has the effect of quickly lowering the bar to the point where no additional 'gain' can be realized. An open question remains: What happens to the goodwill created between the hospital and its medical staff physicians at the point of diminished return? Because of this limitation in duration, we believe that the benefits of gainsharing can be better and more lastingly achieved under less complex (and more tested) contractual models.

2. **CV Management Company.** Management companies are not new, but they have been underutilized as tools to improve the delivery of cardiovascular care. The basic goal in establishing such an entity is to bring together the parties integral to delivering cardiovascular care and to vest them with the power to make managerial and budgeting decisions. This differs from a more common committee-structure approach in that the management company is a full-fledged legal entity with its own budget and clearly specified authority in terms of governance, program oversight, and managerial decision-making. We have found that under this type of structure, physicians come to feel truly involved in the management process, and consequently invest more time and effort to improve the program. While there may be no one-time financial windfall (as in gainsharing programs), the management company can receive fair-market compensation for the efforts of its members, and physicians can legitimately be paid for the time and effort they expend on its behalf. What's more, this model has the potential to be durable. And it can easily be expanded into new areas of care delivery as the relationship between the parties matures.

3. **Outpatient Carve Outs.** Some cardiovascular programs build upon the management company approach by including actual modalities of care and their associated revenues into the entity. For example, it is possible for hospitals and physician practices to consolidate their outpatient diagnostic services (such

as noninvasive diagnostic imaging) into a single entity jointly owned and operated by the venture participants. A diagram of the typical ownership structure and financial relationships between the participants in this model is found in Figure 2. Under this structure the hospital can even outsource certain components inpatient care to the venture and pay it negotiated rates as compensation, if facility constraints don't intervene. This model has obvious benefits in terms of efficiency and reduced duplication of services. Yet more and more we see hospitals and physicians seeking to incorporate an even higher level of care into these types of ventures. (This is often the case because physicians have already developed their own noninvasive diagnostic services in their practices, and these represent a comparatively small source of revenue to hospitals.) If you are going to venture something, the thought process goes, you might as well do it on a scale that will make a difference. Increasingly, the venture of choice is for physicians and hospitals to partner on the development of diagnostic cardiac cath labs. While these ventures can take a number of forms, the following is a typical profile:

- **Cath Lab Type.** Joint ventured cath labs are often primarily outpatient in nature, and handle a wide variety of diagnostic procedure types including diagnostic cardiac cath, peripheral angiography,

Figure 2 – Sample Outpatient Cardiovascular Diagnostics Joint Venture Carve Out

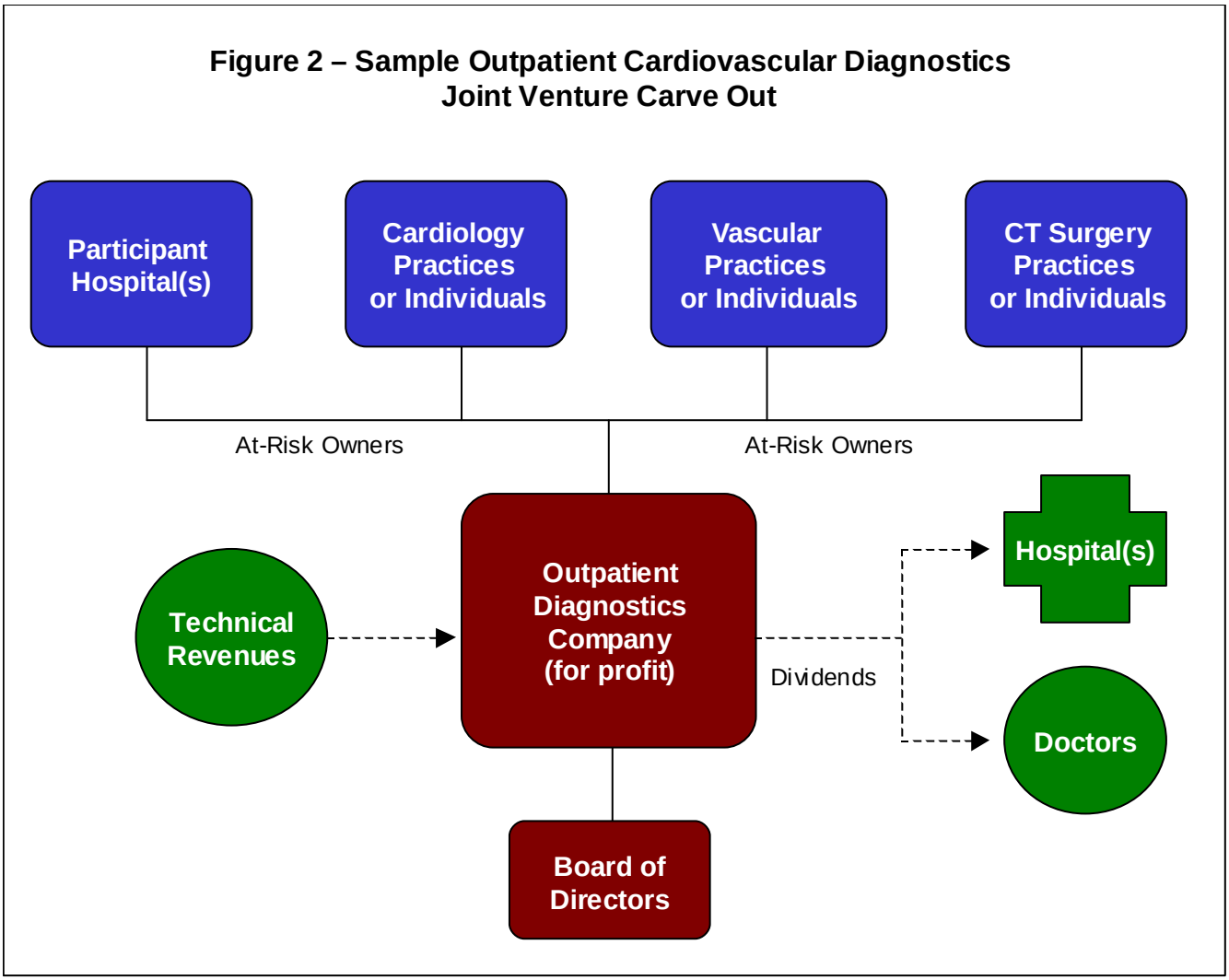


Table 1 - Pro-Forma Annual Income Statements (5 Years; Lease Model)
Joint-Venture Cardiac Cath Lab

	Year 1	Year 2	Year 3	Year 4	Year 5
Utilization					
Outpatient CV Procedures	981	1,131	1,283	1,434	1,507
Average per day (5-day week)	3.8	4.4	4.9	5.5	5.8
Revenues ($000)					
Outpatient Lab Technical Revenue	$ 2,923.0	$ 3,441.7	$ 3,990.0	$ 4,556.8	$ 4,862.3
Expenses ($000)					
Staff FTEs	4.4	4.8	5.5	6.0	6.5
Salaries and Wages	$ 153.1	$ 171.2	$ 204.2	$ 229.5	$ 256.1
Benefits	$ 39.8	$ 44.5	$ 53.1	$ 59.7	$ 66.6
Management Fees	$ 292.3	$ 344.2	$ 399.0	$ 455.7	$ 486.2
Supply Costs	$ 901.4	$ 1,065.2	$ 1,238.6	$ 1,419.0	$ 1,528.5
Utilities	$ 58.5	$ 68.8	$ 79.8	$ 91.1	$ 97.2
Repairs and Maintenance	$ 58.5	$ 68.8	$ 79.8	$ 91.1	$ 97.2
Purchased Services (laundry, etc)	$ 21.9	$ 25.8	$ 29.9	$ 34.2	$ 36.5
IT Management & Maintenance	$ 29.2	$ 25.8	$ 29.9	$ 34.2	$ 36.5
Equipment Leases	$ 234.7	$ 234.7	$ 234.7	$ 234.7	$ 234.7
Insurance	$ 75.0	$ 75.0	$ 75.0	$ 75.0	$ 75.0
Marketing Budget	$ 20.0	$ 20.0	$ 20.0	$ 20.0	$ 20.0
Other Expenses	$ 73.1	$ 86.0	$ 99.7	$ 113.9	$ 121.6
Space Lease	$ 36.0	$ 36.0	$ 36.0	$ 36.0	$ 36.0
Bad Debt/Charity Care	$ 102.3	$ 120.5	$ 139.6	$ 159.5	$ 170.2
Property Taxes and Fees	$ 15.0	$ 15.0	$ 15.0	$ 15.0	$ 15.0
Total Operating Expense	$ 2,110.8	$ 2,401.6	$ 2,734.4	$ 3,068.5	$ 3,277.2
Net Income (Loss) ($000)					
Pre-Tax Net Income (Loss)	$ 812.2	$ 1,040.0	$ 1,255.5	$ 1,488.3	$ 1,585.1
Cumulative	$ 812.2	$ 1,852.2	$ 3,107.7	$ 4,596.0	$ 6,181.1
Key Ratios					
Operating Margin ((NPR-Oper Exp)/NPR)	27.8%	30.2%	31.5%	32.7%	32.6%

Note: Actual experience will vary based on population base, market share, reimbursement rates, and a variety of other factors.

and electrophysiology studies. They can also handle a comparatively smaller number of therapeutic procedures including coronary angioplasty, radiofrequency ablations, and peripheral stenting as technology improves and regulations and payor policies permit.

- **Business Model.** Most cath lab ventures incorporate certain cost-friendly features such as the acquisition of cath lab equipment on a leased basis and staffing patterns based on a standard 8-hour day. All of these features are subject to modification as market conditions change and a base of operational experience is achieved. Management can either be in-house, or outsourced to a capable entity—including the hospital(s) involved in the venture.
- **Equity Capital.** The initial buy-in to such a venture is usually not prohibitive to either hospitals or cardiovascular physicians. It is not uncommon to see start-up capital costs at around $500,000, which will fund necessary pre-opening expenses and cover operating costs until contract reimbursements

are received. This capital is typically provided from the hospital, individual physicians (or practices) wishing to invest in the lab, or a combination including funds from outside sources. The credit rating of the hospital is what can help achieve such low start-up costs.

Based on conservative financial assumptions, a typical joint-venture cath lab with a normal procedure distribution can generate positive net income in the first full year of operation, and in each subsequent year. Increasingly, these ventures are structured as pass-through entities (e.g., as a limited liability company) and all profits are distributed to investors and taxed at a personal rate, where applicable. The management team typically retains an amount of earnings in the entity sufficient to maintain adequate levels of cash reserve. Table 1 shows a typical 5-year profit and loss statement based on the structuring of a successful cath lab joint venture; (actual experience will vary based on the business plan of each specific venture).

Considering the backlog of major infrastructure projects required in U.S. hospitals, there is likely to be ample opportunity to develop these creative financing joint ventures in the future.

4. **Participating CV Bonds.** One of the more innovative methods to align the interests of physicians and hospitals lies in the development of creative financing vehicles that preserve the not-for-profit status of a hospital, but allow for physician investment even in inpatient facilities. One such vehicle, currently about to be implemented for the first time (at Lafayette General Medical Center in Louisiana) involves the private placement of $2 million in tax-exempt participating bonds to physician investors. The bonds are subordinated to other senior bonds, but will pay 10% to 12% interest if the new $75 million heart hospital under development is profitable[6]. While this approach is too new to evaluate the outcome of any potential legal challenge, at least 25 similar deals are currently under development—indicating that the lawyers and government advisors reviewing the deals feel that they will pass muster. This model seems to incorporate enough benefits to be attractive to all of the participants, but few of the downsides that can accompany other types of joint ventures. For example, hospitals get access to a source of capital that understands its business and is in a position to help it reach its development potential, while also helping to deflect the possibility that its physicians might seek more lucrative deals elsewhere. Physicians, for their part, have the chance to earn a return that compares favorably with other investment options, but that limits their exposure by not having to sign on to personal guarantees that often are required under equity model joint ventures. Considering the backlog of major infrastructure projects required in U.S. hospitals, there is likely to be ample opportunity to develop these creative financing joint ventures in the future—and they will likely prove easier to structure and complete than more complex equity-model joint ventures.

5. **Heart Hospitals.** We have previously written on the topic of specialty heart hospitals and concluded that they represent a sound care delivery model[7]. Not all heart hospitals are structured as joint ventures, but when they are they can represent an ideal vehicle for aligning the interests of both hospitals and physicians. We have argued that because of an increasing scarcity

of specialty cardiovascular physicians in many markets, the only way patients and referring physicians are going to achieve a better experience is through the development of care systems designed to make existing cardiovascular physicians more productive. Many specialty heart hospitals achieve this by

Table 2 - Pro-Forma Annual Income Statements (5 Years)
Equity Model Heart Hospital

	Year 1	Year 2	Year 3	Year 4	Year 5
Utilization					
Hospital Admissions	1,900	2,850	3,820	4,240	4,600
Total ED Visits	6,500	9,500	12,400	14,200	16,500
Outpatient Tests & Procedures	3,690	5,522	7,366	8,286	9,205
Revenues ($000)					
Inpatient Revenue	$ 48,714.2	$ 71,865.6	$ 97,738.1	$ 112,129.0	$ 127,097.6
Emergency Dept. Revenue	$ 2,232.4	$ 3,344.7	$ 4,459.5	$ 5,017.0	$ 5,574.4
Outpatient Revenue	$ 10,182.1	$ 15,715.6	$ 20,969.4	$ 23,591.0	$ 26,206.5
Gross Patient Charges	$ 61,128.7	$ 90,925.9	$ 123,167.0	$ 140,736.9	$ 158,878.5
Less: Allowance for CA/Disc	$ (29,341.8)	$ (43,644.4)	$ (59,120.2)	$ (67,553.7)	$ (76,261.7)
Net Patient Revenues	$ 31,786.9	$ 47,281.5	$ 64,046.9	$ 73,183.2	$ 82,616.8
Expenses ($000)					
Staff FTEs	99.0	139.3	176.5	188.0	209.0
Salaries and Wages	$ 4,157.7	$ 6,145.2	$ 8,171.4	$ 9,142.5	$ 10,669.8
Benefits	$ 1,039.4	$ 1,536.3	$ 2,042.8	$ 2,285.6	$ 2,667.5
Professional & Management Fees	$ 825.0	$ 825.0	$ 825.0	$ 825.0	$ 825.0
Emergency Department Supply Costs	$ 533.0	$ 839.5	$ 1,175.3	$ 1,388.3	$ 1,619.7
Outpatient Diagnostics Supply Costs	$ 533.0	$ 550.9	$ 771.5	$ 911.3	$ 1,062.9
Admitted Patients Supply Costs	$ 10,182.1	$ 15,801.9	$ 22,118.0	$ 26,121.5	$ 30,485.3
Utilities	$ 635.7	$ 945.6	$ 1,280.9	$ 1,463.7	$ 1,652.3
Repairs and Maintenance	$ 794.7	$ 1,182.0	$ 1,601.2	$ 1,829.6	$ 2,065.4
Outsource Contracts (food, laundry)	$ 556.3	$ 827.4	$ 1,120.8	$ 1,280.7	$ 1,445.8
IT Management & Maintenance	$ 238.4	$ 354.6	$ 480.4	$ 548.9	$ 619.6
Equipment Leases	$ 1,512.1	$ 1,512.1	$ 1,512.1	$ 1,512.1	$ 1,512.1
Modular Building Lease	$ 21.0	$ 21.0	$ 21.0	$ 21.0	$ 21.0
Insurance	$ 250.0	$ 300.0	$ 350.0	$ 375.0	$ 250.0
Marketing Budget	$ 250.0	$ 250.0	$ 250.0	$ 250.0	$ 250.0
Other Expenses	$ 794.7	$ 1,182.0	$ 1,601.2	$ 1,829.6	$ 2,065.4
Interest Expense	$ 1,335.1	$ 1,316.8	$ 1,297.1	$ 1,275.8	$ 1,252.8
Depreciation and Amortization	$ 1,045.8	$ 1,317.3	$ 1,663.2	$ 2,454.2	$ 2,880.2
Bad Debt/Charity Care	$ 3,178.7	$ 4,728.1	$ 6,404.7	$ 7,318.3	$ 8,261.7
Property Taxes and Fees	$ 225.0	$ 315.0	$ 450.0	$ 450.0	$ 450.0
Total Operating Expense	$ 27,925.1	$ 39,950.8	$ 53,136.5	$ 61,283.0	$ 70,056.4
Non-Operating Income ($000)					
Interest Income	$ 30.0	$ 30.0	$ 30.0	$ 30.0	$ 30.0
Other Income	$ 95.4	$ 141.8	$ 192.1	$ 219.5	$ 247.9
Total Non-Operating Income	$ 125.4	$ 171.8	$ 222.1	$ 249.5	$ 277.9
Net Income (Loss)					
Pre-Tax Net Income (Loss)	$ 3,987.2	$ 7,502.6	$ 11,132.5	$ 12,149.8	$ 12,838.2
Key Statistics					
Net Revenue ($000)/FTE	$ 321.1	$ 339.3	$ 362.9	$ 389.2	$ 395.3
Operating Margin ((NPR-Oper Exp)/NPR)	12.1%	15.5%	17.0%	16.3%	15.2%
Cash Flow Margin (EBITDA/NPR)	20.0%	21.4%	22.0%	21.7%	20.5%

Note: Actual experience will vary based on population base, market share, reimbursement rates, and a variety of other factors.

performing better than traditional hospitals on a number of cost and quality measures, positioning them well in any policy debate on the viability of the specialty hospital model—so we don't expect the model to be legislated away. We have found that, regardless of ownership or financial status, specialty heart hospitals can raise the bar for quality in a market and also place downward pressure on costs by giving insurers options to contract with the low-cost leader. In specialty heart hospitals labor costs sometimes amount to less than half the costs of programs of comparable patient volumes. And this does not even factor in the savings achieved from increased employee satisfaction with their working environment and reduced turnover costs. The finances of a heart hospital are very similar to the finances of a hospital cardiovascular service line. (See Table 2 for a sample 5-year profit and loss statement for a full service specialty heart hospital.) While the profit margins may not rival those of a joint venture cath lab, the revenue base is much larger, so the potential return for all participants is much greater. All told, there is a sound clinical and business case to be made for developing joint-venture heart hospitals.

Legal Issues Surrounding Healthcare Joint Ventures

Recently (April 2003), the Office of Inspector General issued a Special Advisory Bulletin regarding healthcare joint ventures. It noted concern on the part of the OIG regarding the proliferation of certain contractual joint venture arrangements that may violate the terms of its 1989 Special Fraud Alert[8]. Because of the statutory and regulatory restrictions peculiar to healthcare, it is important to design all physician-hospital ventures to withstand legal scrutiny. Designing successful hospital-physician relationships requires adept maneuvering through many legal and regulatory provisions, because the wrong business structure can cause legal liability for both the hospital and physicians. More importantly, mutual confidence and trust are created when both sides have a solid understanding of the legal and regulatory environment and have carefully considered all of their options. A core set of legal considerations is important in nearly every hospital-physician joint venture[9].

- **Self-Referral Statute ("Stark"):** This law prohibits physicians from referring patients for certain health services (e.g., radiology, hospital inpatient and outpatient services) to any entity with which the physician has a financial relationship, unless an exception applies. With reference to cardiovascular care, cath lab services and nuclear medicine services are not designated (prohibited) under Stark; echocardiography is.
- **Anti-kickback Statute:** This statute makes it a criminal felony to pay or receive anything of value in return for inducing referrals of patients covered under federal health care programs (e.g. Medicare and Medicaid). But certain arrangements fitting within a "safe harbor" are guaranteed to be free from challenge. Arrangements that do not neatly fit safe harbors may be also considered but must be evaluated case-by-case using an intent-based standard.
- **Tax-Exemption:** Participation in a business arrangement with physicians can create monetary sanctions for a tax-exempt hospital, and can even jeopardize a hospital's tax-exempt status. An

appropriate tax-exemption analysis involves an assessment of the fundamental reasons for entering the arrangement. If the honest answer is to improve service, access, or otherwise benefit the community, then the risk is probably minimal. If the answer is instead to provide a for-profit physician group with a share of the hospital's profits, then the arrangement would be suspect.

- **Reimbursement:** The set of relevant reimbursement issues and questions depends on the services, site of service, and other factors. Those issues and questions should be identified and analyzed in advance, along with the other critical legal matters. Establishing a structure that won't be reimbursed under federal programs would likely doom the venture. In addition, asking and answering questions about provider-based status and office-versus-hospital reimbursement rates and other similar topics can reveal hidden, but entirely appropriate and legal, revenue opportunities.

Cardiovascular Joint Ventures Involving Facilities

In cardiovascular ventures between hospitals and physicians that involve facilities and/or real estate, the models must also comply with applicable provisions in the federal Stark law, the federal anti-kickback statute and tax-exemption regulations[10]. If a venture is structured as a traditional real estate venture (i.e., owner and landlord) and the facility is not acting as an actual "provider" of health care services, the referral prohibition of the Stark law will not apply. However, if the venture entity is intended to be a provider furnishing designated health services, the venture must qualify under an existing exception to Stark. Outpatient surgery centers and entire hospitals are not impacted by Stark prohibitions. If a not-for-profit hospital and physicians are prospective partners in any health care facility, the venture must also comply with the anti-kickback statute and tax-exemption regulations. The fundamental standard for anti-kickback and tax exemption tests is fair market value. If the financial relationship is consistent with fair market value and is not tied to referrals, the relationship should withstand regulatory scrutiny. Because it is often difficult to separate the business motivations for rewarding referrals from an otherwise proper business arrangement, sometimes hospitals and physicians involve outside, passive investors. For example, third party investors with no referral or clinical relationships ("financial investors") may desire to invest in a health care facility. If physician investors participate in the venture on the same terms and conditions as the financial investors, it is clear that no "special" treatment is bestowed upon the physicians in the transaction. Many developers are often willing to participate as equity partners, so it is usually not difficult to find experienced financial investors to participate and to substantiate the fair market value of investments made by physicians.

Top 10 Reasons a CV Joint Venture May be Appropriate for You

Not every venture model is appropriate in every environment. But if you find yourself agreeing with all or many of the following statements, you may have a cardiovascular joint venture in your future:

1. **You need to improve your program's outcomes.**
   Every program needs to know where it stands in terms of quality measures, and have a plan for improvement. But you need the active—and sustained—engagement of both the hospital and its cardiovascular physicians. A cardiovascular joint venture can create the ideal forum necessary to stimulate lasting change throughout an entire program.

2. **You need to demonstrate the financial benefits of your services.**
   It's not enough to simply track your own costs. You must be able to show consumers and insurers what they are getting for their money. Major studies have documented a 2 to 1 financial return to the community for every dollar in healthcare expenditures. Cardiovascular economic partnerships informed by global hospital and physician data offer more complete information.

3. **You are facing increased competition.**
   It's not always the cross-town hospital. It can be Wall Street. It can be your payors—if you're not careful, it can be your own staff and physicians. Don't be content to simply track your own data; you need to outwit your competition and gain a competitive advantage by creating physician loyalty. Lock them in through economic partnerships.

4. **Your CV financial ratios are deteriorating.**
   Full-service cardiovascular programs typically generate 30-35% of total general acute-care hospital revenues (in some cases over 40%). Well-run programs achieve margins of 15-20% of net program collections, or more. If your results are any less, you can do better by creating economic partnerships with your cardiovascular physicians through joint ventures.

5. **You need to expand your scope of services.**
   New technologies and regulations have changed the playing field, and your cardiovascular program needs to respond. By adding new diagnostic, interventional & surgical modalities you can enhance patient care and be responsive to market demands. By adding them in partnership with your physicians you can stay ahead of the curve—and make sure someone else doesn't beat you to the punch.

6. **You need to expand your service area.**

   Cardiac programs are tertiary in nature. You must do more than meet the needs of your immediate catchment area—and you can't afford to sit back and wait for referrals. In order to thrive you must reach out. But ultimately it is the physicians who will drive patients to your facility, or to another's. Give them the choice of performing their work in 'their own' facility.

7. **Your hospital is not considered 'physician friendly'.**

   Perhaps the most important strategy hospitals can pursue to enhance their results is to partner with physicians on business development and operational improvement. But this willingness needs to be shown in both word and deed—actions that promote quality and growth should be rewarded. Making it explicit through a formal joint venture leaves no room for doubt about your intent.

8. **Your patient acuity mix is out of balance.**

   If your ED provides a disproportionate number of your total cardiovascular patients your quality indicators will suffer and the financial and productivity impact will be felt hospital wide. But it doesn't have to be that way. Partnering with your physicians can make them more productive and free them up to see new patients in a more timely fashion. Improved costs and outcomes will then follow.

9. **Your operating benchmarks don't qualify you for anyone's Top 100.**

   As a complex organization your cardiovascular program requires constant tuning: Lengths of stay should be neither too long nor too short; the mix of inpatient & outpatient beds needs to reflect best practices. And the list goes on. Periodic adjustment is crucial for sustainable growth—but you need your physicians to understand this need and to buy in to the process. Make them co-owners of these services and you won't need to rely on the power of persuasion.

10. **You need new facilities.**

    Optimally laid out facilities can add as much as 10 percentage points of profit on operations. That often translates into millions of dollars saved—dollars that are then available for investment in other areas. But planning for and building new cardiovascular facilities is resource intensive and financially risky. Hedge your bet by partnering with your physicians. Make sure that they will be there to help you fill and efficiently manage the new space.

A willingness to create economic partnerships can go a long way towards ensuring the growth and sustainability of a cardiovascular program. If you see yourself in the above list—but don't know exactly how to proceed—we can help by performing a *Strategic Assessment* of your cardiovascular services. With a basic set of data and two days of meetings with key individuals on site, our team can accurately assess your situation, report back, and outline a sound process for improvement. You are welcome to contact us on these matters.

About the Authors

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Kevin Curtis. Over more than a decade Kevin has prepared and implemented strategic plans for the development of numerous hospital cardiovascular programs and physician practices around the country. His special interests include building better physician-hospital relationships and creating effective systems of comprehensive cardiovascular care. He has an especially extensive background in the development of cardiovascular medical practices, outpatient Heart Centers, Heart Hospitals, and Vascular Centers. Kevin has Bachelors degrees in Economics and Finance; and, a Masters in Business Administration. He can be reached by e-mail at *kcurtis@healthgroupwest.com*.

About HealthGroup West

HealthGroup West is expert in the planning and development of cardiac and vascular healthcare services. It is one of the most knowledgeable groups of experts in the country on the development of cardiovascular markets and all types of specialized cardiovascular facilities. Collectively, the full-time staff and special advisors of HealthGroup West, LLC represent many years of hands-on experience in the analysis and development of cardiovascular and other specialty medical services. They hold advanced degrees in the fields of Business Administration, Health Policy, Information Science, Medicine, Law, Clinical Sciences, and others. We welcome your feedback and comments on this report.

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Endnotes

[1] OIG Special Advisory Bulletin, April 2003.

[2] OIG Special Advisory Bulletin, 59 Federal Register 65372 (December 19, 1994).

[3] Elliott S. Fisher, MD, MPH et al. "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care." *Ann Intern Med.* 2003;138:273-287.

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[7] Frazier, Jeffrey et al. "The Emerging Heart Hospital Standard: How Specialty Heart Hospitals are Setting New Benchmarks for Quality, Productivity, & Profitability in Cardiovascular Care." July 2002.

[8] OIG Special Advisory Bulletin, April 2003.

[9] Much of the legal analysis in this section has been adapted from the published comments of Ross D'Emanuele, J.D. as appearing in: Zismer, Daniel K., "Physician Relations: The Achilles Heel of Hospital CEOs," *Discovery*, February 2003.

[10] Much of the legal analysis in this section has been adapted from the published comments of Forest G. Burke, J.D. as appearing in: Zismer, Daniel K., and Hamel, Mark, "Healthcare Facilities as Strategy," *Discovery*, March 2003.