



Building Joint Ventures that Work

About the HFMA Executive Roundtable Series

The HFMA Executive Roundtables are a series of discussions among healthcare leaders who have come together to share their experiences with and solutions to pressing healthcare finance issues. This roundtable is sponsored by GE Commercial Finance Healthcare Financial Services.

As payments continue to shrink, hospitals and physician groups find themselves forced to operate on increasingly thin margins. Therefore, in an effort to improve patient volumes and enhance revenue streams, many of these organizations are partnering with each other through joint ventures. However, regulatory issues, business concerns, and a lack of trust between hospitals and physicians can sometimes make these arrangements difficult or impossible. How can these parties build business relationships that are mutually beneficial?

HFMA recently brought together a group of healthcare finance executives to learn whether their organizations are taking part in joint ventures with physician groups and how well they are working. The following are highlights of their discussion.

THE PARTICIPANTS IN THIS HFMA ROUNDTABLE WERE:

Linda Dupuis, senior counsel for University Community Hospital, Tampa, Fla.

Eric Feder, chief operating officer for Bayfront Health System, St. Petersburg, Fla.

Richard Green, chief operating officer for the Centers of Advanced Healthcare for the University of South Florida, Tampa, Fla.

Mohamad Kasti, chief operating officer for the University of South Florida Health Sciences Center, Tampa, Fla.

James Kennedy, attorney, outside counsel for Tampa General Hospital, Tampa, Fla.

Steve L. Short, senior vice president and chief financial officer for Tampa General Hospital.

Dale Skrnich, vice president of operations for AmMed, Inc. diagnostic imaging centers, based in St. Petersburg, Fla.

Robert W. Thornton, CPA, vice president of finance and chief financial officer, Bayfront Medical Center.

William E. Woeltjen, CPA, corporate treasurer, University Community Health.

Representing the roundtable sponsor were **Paul Castillo**, financial services account manager, and **Andrew Harris**, managing director of the strategic relationship group for GE Commercial Finance Healthcare Financial Services.

The moderator for the discussion was **Lee Guthrie**, vice president of marketing for the Healthcare Financial Management Association.

ROUNDTABLE DISCUSSION

► **Guthrie: What is the joint venture activity like in this market?**

► **Feder:** We're seeing quite a few joint ventures in our market, particularly between physicians and institutions doing endoscopy centers. That seems to be very popular at the moment.

► **Short:** We have a lot of collaborative efforts between hospitals and physicians, but there are not too many true legal joint ventures.

► **Kennedy:** Right now, we have four endoscopy deals, three cardiac imaging deals, three ambulatory surgery centers, and a host of very subspecialized joint ventures.

► **Thornton:** Groups are approaching our institution saying, "Reimbursements are declining, and in order for us to grow as a group and recruit new physicians to our organization, we have to have lower overhead. To do that, we need to find more ancillary revenues to offset some of our overhead costs. Therefore, we need to get into more of what the hospital does. That may be a joint venture or that may be head-to-head competition, but we prefer to form partnerships."

► **Guthrie: Do physicians primarily approach hospitals with joint venture proposals?**

► **Feder:** The physicians have initiated most of the discussions that we've had. In the first joint venture that Bayfront ever did, the physicians approached us about an ambulatory surgery center. A large group of physicians on the campus had another institution offer them that opportunity, but they indicated they preferred to do it with us, so we started to work with that group.

► **Woeltjen:** It's typically the physicians approaching the hospitals. Hospitals are somewhat reluctant to share with the physicians, but we see the need for the physicians to participate, and we would rather work as partners than fight with them.

► **Harris:** In markets like this where there's a lot of competition, physicians tend to approach hospitals with joint venture proposals more often. In other markets, especially more rural markets where the hospitals are somewhat dominant, the hospitals are coming up with the joint venture ideas. They're going to the docs and saying, "We need to do this, because we're worried about some outside group coming in."

► **Short:** There are instances where large physician groups have been very successful and have established themselves, and hospitals approach them and say, “Perhaps we can both grow bigger by coming together in some fashion.”

► **Guthrie:** In the initial stages of exploring a joint venture, do physicians know how joint ventures with hospitals work and understand the different expectations that each party has?

► **Woeltjen:** I think they have an understanding of how things work. Since we’re a tax-exempt organization, though, they don’t always understand some of the limitations that we’re under, and that makes what could be an easy deal somewhat more complex.

► **Skrnich:** As a third-party provider and not a hospital or physician, we tend to see that as well—they don’t necessarily understand all the ramifications of joint ventures. They have an idea, but don’t necessarily know how to put it together.

► **Kasti:** The variations depend on the size and maturity of the physician group. Smaller groups may not be able to understand the ramifications. Larger groups became large by going through growth and joint ventures, and they understand those ramifications, or they can afford to hire counsel to guide them.

► **Green:** A lot of the physicians are entrepreneurial. They understand the business model and can understand the numbers. The problem comes when you start talking about the legal issues, especially when you’re dealing with larger organizations and their attorneys. The process of starting a joint venture just tends to take a long time and gets bogged down in the legal issues.

► **Feder:** It depends on the particular venture the parties are looking at. We’ve seen the same group be fairly logical about one arrangement and totally illogical about another one, not only from the legal standpoint, but just from the business model that they were proposing. The legal issues and the business issues can be pretty closely intertwined sometimes.

Physicians often want a lot of control, but they don’t realize that the IRS and the antitrust laws, especially like in the area of managed care contracting, don’t allow the not-for-profit to give that control.

► **Thornton:** The legal issues are always a concern. With all these ventures, there is always the same series of legal issues related to physicians and healthcare institutions—a for-profit group and a not-for-profit organization—working together in partnership. The business issues vary, obviously, from deal to deal.

► **Guthrie:** How do you communicate the business model and the legal issues to physicians to help them understand these issues?

► **Short:** The groups that have been successful and have grown large are very business savvy. They take on good business practices; they work very hard on customer relations and what the patient’s experience is going to be like. I’ve seen that with at least three of the large groups that we are associated with at Tampa General. It has been my experience that the smaller groups are not as up-to-date on what all that entails.

► **Green:** It’s a little bit easier to deal with larger practices, because they have a management infrastructure. They know they need a CEO and a businessperson to run their operations, so they’re obviously more in tune to the business piece. The smaller groups don’t have the luxury of affording that high-salary businessperson to run their practice. They still may have their spouse or a friend doing their business dealings, or they bring in an outside attorney or somebody who may not fully understand their practice and what they’re trying to get out of it.

► **Kasti:** Going back to your question, we need to start with: What is a joint venture? What does it mean? People throw around the word “partnership”—what does it mean? Then there’s a whole process of creating the joint entity. You have to figure out that process, but even for some of us who have gone through it, every time it’s a little bit different. If I’m a physician, what does it mean to go through this? Where do I start? How do I protect my interest but also work with the other entity?

There are also cultural implications. Physicians are trained to work *with* the hospital, but they don’t work *for* the hospital. When they go into a joint venture, they become an owner, so the decisions they have to make are different than when they were working in the hospital and didn’t have to worry about the cost implications. Those things change the physicians’ dynamics. Sometimes the proceedings get to the point where the physicians are in agreement, but when they come to understand how the venture is going to affect the way they practice they say, “No, we can’t do this deal.” It goes back to the business maturity of the group.

► **Kennedy:** I agree with that. Another important question is expectations. In the joint venture process, it’s critical that at the first or second meeting a timeline is set out, because for many physicians this is their first or second time doing this. It’s important to establish the expectations that this is a three-month or six-month process and have targets as to what we’re going to accomplish.

It’s also important to suggest to them that if they don’t have internal help, they need to get some. I agree with the comment that the groups that have business people running them, or assisting them, are so much better off in terms of putting deals together, understanding the numbers and what the real financial implications will be.

Then, if you have a clinical piece—for example, if you need to tell physicians that for this sharing deal to work, they’re going to have to use a different implant—you need to set that out at the early stages so there’s not a surprise at the end.

► **Dupuis:** It’s helpful for the physician group to get a good healthcare attorney, because it’s not only business savvy that’s needed. A lot of times the business terms are in direct conflict with regulatory laws. As in-house counsel, it’s difficult to make the point, “Hey, the hospital just can’t do this,” unless the physician group is also represented by someone who knows these laws pretty well.

► **Guthrie:** Does the knowledge to be able to work through the process with the hospital only come from counsel? Or does it come from other sources?

► **Kasti:** The counsel is one piece of it. Counsel could work on one dimension, which is the legal aspect of how the joint venture is going to be successful, what this partnership is going to look like, what the processes are going to look like, how we are going to get patients in the door, what’s going to be your responsibility versus my responsibility, and how the desired outcome will be reached. Counsel can put the framework around it.

You have to come into the discussions knowing what is critical to your success. I have to say, “Here’s what’s important for me to get out of this deal” and you have to tell me what’s important to you, and then we can design around it.

► **Short:** That’s key. I call it the due diligence process, and the process that goes on before you ever even get close to signing documents. You’ve spelled out things like what the expectations are, what each party wants out of the deal when it’s done, and what it’s going to look like when it’s up and running. Otherwise, you come together at the end of the day and find out that you don’t want the same thing, and there’s no point in risking failure by going forward. That due diligence is a critical process to go through. The parties really have to understand each other to make it a good partnership. It becomes like a marriage.

► **Green:** We’ve been successful by starting with just that kind of discussion. From that, we devise a letter of intent, and we list the 10 or 15 items—just bullet points—that we all agree indicate what this venture

is going to be. Then we put a timeline out there, usually about 60 days, to do the due diligence piece, and at that point, we either come to an agreement or we move on. The biggest piece is what we agree on, and then we work through those other issues. Obviously, legal review is always a big piece, because some of those things that we may agree on may be in very gray legal areas.

► **Kasti:** It's not a difficult process. It's like you're designing a new product. The product is a partnership, and so you have to decide: What are the expectations? What does the customer want? (in this case, we're the customers) What are the things that we need to do to develop and maintain the product? Where could things fail?

► **Guthrie:** In terms of the due diligence part of the process, where do you think people most often fall down? What's the piece that most often doesn't work well?

► **Green:** There are two big issues. The first is trust. There has to be a relationship of trust between the two parties. I haven't been able to do any joint ventures when the two parties don't trust each other.

The second is determining where the control lies. What do the physicians control? What does the hospital control? What does the university control? That tends to be where things fall apart.

► **Kennedy:** I agree. Physicians often want a lot of control, but they don't realize that the IRS and the antitrust laws, especially like in the area of managed care contracting, don't allow the not-for-profit to give that control. Trying to work through those considerations can be difficult.

► **Harris:** Realistic projections and risk expectations are very important. If the parties have really optimistic expectations of what's going to happen in the joint venture and then it doesn't happen, everybody starts running for the exits and things fall apart fast. A lot of people don't think about the risks, but as a lender, of course, that's all we think about.

Something you have to find out as quickly as possible is what the physician structure is and how they are going to make their ultimate decision.

► **Green:** Something you have to find out as quickly as possible is what the physician structure is and how they are going to make their ultimate decision. Otherwise, you might go through all these discussions with one lead physician, or maybe one lead business person, but then suddenly find out that the rest of the group doesn't back it and that they've got to get a unanimous vote by their board.

► **Kasti:** The same thing can happen on the hospital side, too—you think everybody's on the same page, but they're not. You have more dynamics to deal with in the hospitals because you also have all the physician groups that are already there. You have that physician who has been with you, but then there's this physician on the outside trying to form a partnership with you. You really need to be realistic about defining the partnership and making sure everybody understands it.

► **Thornton:** You can get past all those issues if whatever you propose has some kind of win/win for both sides of the partnership. If it's win/lose or win/neutral, a lot of times you won't be able to close the deal.

► **Guthrie:** What are some of the most challenging compliance issues that you face? How do you discuss those with physicians?

► **Skrnich:** The antikickback rules.

► **Thornton:** I think physicians inherently see their referral streams as their assets. It's hard to get across to them that referrals into the joint entity creating the profit are an asset of the entity, not theirs. To get that across, it often takes lawyers talking to lawyers.

► **Feder:** We've spent untold extra dollars having our attorneys write educational white papers on what's legal, how referral sources have to work, etc. We've done this even for very sophisticated groups, because they don't think of these issues the same way. The largest part of some of our joint venture discussions has been education about what can be done.

► **Kasti:** We've seen significant successes using a third-party facilitator—that's where trust gets built—and talking through the issues rather than turning it over to the lawyers.

► **Kennedy:** I had an experience with third-party mediation about three months ago when a hospital and physician group could not agree. They needed each other, but there was no trust by either and hadn't been for a long time. We wound up getting a business mediator—he was actually an accountant—for a weekend meeting. The rules were that the physicians, the hospital people, and the mediator were in the room, and the lawyers and accountants had to stay outside. The principals would talk about the issues and when questions came up, they could come talk to their lawyers and accountants, but the counselors couldn't go in the room. By the end of the weekend, the deal was done. It was a very good process—expensive, but it worked.

► **Guthrie: What do physicians want from hospitals, what do hospitals want from physicians, and what are the issues that come up as each group asks the other for demonstration of performance?**

► **Short:** It all comes down really to driving the volume. Volume leads to things like work hours and productivity measures, which lead to the expenses and standardizing products and issues like that. Volume encompasses the total financial operation.

► **Feder:** It does help to closely align the issues of both sides of the table. Once you get past some of the general assumptions and reach some basic agreements

on common goals, all of those discussions around utilization and preferences and those kinds of things seem to be much more likely to be resolved in a way that benefits the new partnership. We've found that to be very positive.

► **Guthrie: When you say the area of joint ventures is growing, is the growth coming from the larger, more sophisticated physician groups or from smaller groups?**

► **Skrnich:** I would say both. Certainly the larger groups in the larger hospitals see a need to secure those services, but the smaller groups and the third-party entities also see the opportunity to do that.

► **Green:** The smaller groups right now are trying to create affiliations and relationships and are kind of easing their way into the joint ventures. They want to make sure that they're not subsumed. I don't think a lot of them have gotten to the joint venture point, but they're trying to affiliate to make sure that they're going to survive.

► **Kasti:** We all know it's a fragmented market, but at a certain point the market forces will drive consolidations. We saw the trend in physicians leaving the hospital and setting up their own outpatient imaging services. Now the trend is not only that physicians are coming to the hospitals and saying, "Let's do a joint venture," there's also the hospital saying, "Hey, don't do your own set up—let's do something together."

► **Short:** Hospitals have a dilemma in that they have very thin margins. They have big facilities that they have to capitalize. When you combine all that, from the hospital's standpoint, some of these joint ventures are defensive strategy. To defend your market share, you have to give something away, which makes it that much more difficult to achieve the rest of the goals you have as a hospital.

► **Feder:** But if you keep doing it multiple times, there's only so much margin you can give away before you finally have none left, and you've joint-ventured yourself right out of any real profitability.

► **Short:** When you come together with doctors, you can become bigger than you were. Given the right situation, and a market that is somewhat untapped, you can have a win/win partnership with a physician group. If that market dynamic is absent, then you stand to lose more.

► **Kasti:** There is also the consideration about whether a joint venture would be better for the patient. Sometimes it's not about getting bigger. Sometimes it's just about providing better service, instead of further fragmenting our market. We need to look at those opportunities where it's a better model when you have the performers aligned together.

► **Kennedy:** That can be a tough sell, though. I'm working on a deal now for an oncology joint venture. It's one of the few I've had where the pro formas show no profitability for three years, but the physicians at the hospital made a commitment. They view it as a growing but underserved area of our oncology services, and they're going to make the investment.

My experience, though, is that most frequently the parties are looking for an immediate return. They want a quick cut into the hospital pie. It's great to structure a joint venture in a way that provides some short-term win for both sides — I think that's psychologically important — but it isn't common to see a joint venture that's willing to wait for the market, looking geographically where the market's going or take on financial risk to address an underserved area.

Sponsored by:

GE Commercial Finance
Healthcare Financial Services

