

HOSPITAL-PHYSICIAN JOINT VENTURES: A PROMISING PARTNERSHIP?

TRANSCRIPT OF LIVE SYMPOSIUM PANEL DISCUSSION*

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MR. PEMBERTON: Our goal today is to respond and elaborate on some of the themes that Professor Blumstein proposed earlier this afternoon in such an eloquent way. Namely, the integration to which he referred repeatedly: the idea that a hospital and a physician must find a way to work collaboratively and have aligned incentives to reach quality outcomes, and therefore, triumph in the marketplace. There are many concepts in these few words, but that is really the kind of insight that we are going to hope to bring to the topic. We think we have struck a nice blend between the practical implications, what is actually happening in terms of achieving this model that Professor Blumstein proposed and what is actually going on in the field, by sharing some hands-on experience. I think you will find a good combination of a very real world experience both locally, regionally, and in Mike Finnerty's case, even on a national scale.

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With that, let me pose the first question, and it will go to Norman Tabler. Norm is the general counsel of Clarian Health Partners and has had a very practical hospital-physician integration project, which they are currently working on. If you would, Norm, take a few minutes and share some of the insights and lessons learned.

MR. TABLER: Sure. I want to talk about what I think is the primary cause of the dysfunction and the increasing dysfunction of the traditional hospital-physician relationship. I want to talk in particular about a concrete example that my organization is using to try to address this. We at the organization are hopeful that this will be effective and perhaps one model for repairing some of the problems that Professor Blumstein has talked about.

The problem is disaggregation. It is the fact that when we have the medical care in America, particularly when it is in a hospital facility, really whether inpatient or outpatient, there is a complete disaggregation of the interests of the various economic components. The various components are not aligned. They are competitive, as Professor Blumstein elaborated on, and often, they are precisely in conflict. Now, typically in America from day to day we don't really know this. We think of a hospital generally, certainly lay people do, as an integrated single entity, and I think the typical American finds out otherwise when he starts to get invoices after a stay at the hospital.

I had some fairly routine surgery a couple of weeks ago, and to do that, I interacted first with the primary care physician who referred me to a surgeon. This surgeon scheduled an appointment at the hospital. I interacted with an anesthesiologist and I think if I were not in the business, I would have assumed that all, if not certainly most of these physicians, were related and part of a single economic unit. But anybody who thinks that will be completely disabused as the invoices start to roll in, because you get an invoice from the primary care physician, from the anesthesiologist, from the surgeon, from the hospital, from the laboratory. Those entities typically have no economic relationship with one another, and for reasons that were outlined earlier today, it is often illegal for them to have economic relations.

Think of any other experience you have with the American economy and certainly with an important industry, you'll find that it is completely opposite. If you fly in an airplane, you would be stunned to get bills from the airplane owner, from the pilot, from the flight attendant, from the baggage handler and from the flight control personnel. If you have a car repaired, you would be astonished if you got a facility fee, another bill for parts, and another bill for labor.

And the damage is not just that there is no alignment or aggregation or integration of these economic interests. The fact is they are very seriously at odds with one another in a lot of ways. A simple example would be that the typical hospital today is paid on a diagnosis-related group ("DRG") basis. That means that the hospital is going to get paid the same amount of money for a stay, no matter how long or short it is. Therefore, it is in the hospital's economic inter-

est to have a short stay; however, the physician has an interest in a long stay. A physician has an interest in consultations on several days, rather than just one. The operating room is another example. It is in the surgeon's interest to block as much time, and to hold the blocked time in the operating room as much as possible. It is in the surgeon's interest to order more blood than he might need at a direct cost to the hospital.

Now, why do we have in this industry, this important industry of hospitals and medicine, this disaggregation? It is curious, because the answer is not that hospitals do not want to play by the normal rules, it is that they are not allowed to play by the normal rules that other industries follow.

The obstacles to integration also include simply tradition and culture. For example, the tradition in America is that physicians want to be independent. A person is motivated to go to medical school in part because he or she wants independence and wants to be in control of his or her own destiny. I might say, parenthetically, that this seems to be changing. We increasingly see physicians who really do want to be employees.

We also have a cultural bias in the general attitude of the public. In some of the cases we heard about earlier, the traditional view, and really the view that still exists today, is that an exempt hospital has a duty to care for a patient who cannot pay. If the hospital does not fulfill that duty, then there is no community benefit. We do not apply that to any other industry, including nonprofit industries. We would not say that a university serves no public benefit because it refuses to admit students who do not pay the tuition. We would say that education in itself is a community benefit. Moreover, the list of laws and regulations, including the anti-referral laws, the antitrust laws, the Stark law, the laws of 26 U.S.C. §501(c)(3), all also create obstacles.

I want to give you an example of something that we are just starting, in fact, two weeks from today, at this very hour, we are going to have the topping-off ceremony in Lafayette. Clarian has joined forces with the Arnett Clinic to create a new general hospital, likely known as Clarian Arnett, in Lafayette. The Arnett Clinic is a one hundred and fifty-odd physician specialty group. It is one of the oldest large multi-specialty groups in the United States, dating back to the 1920s.

We have joined forces, and we are going to build a hospital of one hundred and fifty beds, an outpatient center, and an attached medical office building. It is going to be a general hospital. That makes it different from other hospital ventures that you see. It is going to have an open staff. It was designed originally by the Arnett Clinic physicians.

It is going to be a sixty/fifty LLC, Clarian sixty percent, and the clinic forty percent. I will tell you why we have that that number in a second. The clinic is contributing all assets, including all future income streams other than the professional fees. So they are contributing all ancillary income and the technical component of fees.

We really think of ourselves as fifty/fifty partners, so why the sixty/fifty division? One reason is the legal obstacle of the antitrust law. Our market in

central Indiana over at Clarian overlaps with the market of the hospital we are building, and we would be competitors of one another if we were not in control. So that was a powerful motivation for Clarian to have well over fifty percent. There are considerations under the law of tax-exempt organizations that make it better and safer for us to control the organization rather than to be an equal partner, and the sixty/forty split is one of the prongs of an anti-referral law safe harbor.

I want to very briefly tell you some of the disadvantages and, some of the advantages that we foresee. Normally, I would start with the advantages, but I want to end on a high note. The disadvantages are that we were forced to use taxable financing. For an organization like ours that is used to the benefit of tax-exempt bonds, it is pretty sobering to go into the taxable market.

We will have to look over our shoulders for the IRS throughout the operation of this venture because of the rules that apply to us under 501(c)(3). We have a concern that the ever increasing number of taxable ventures will cause a substantial part of our operations to be for-profit, and that is a test that we cannot afford to fail.

I think it is also a risk to build a general hospital. New hospitals, the new physician-hospital ventures you hear about, are almost invariably specialty hospitals, and it is not an accident that the specialties that are hit are the high-income specialties. We are going to try to create a general hospital.

Perhaps one of the most basic questions of all is whether the community can and will support another hospital. Lafayette is a one-hospital town. They long had two competing hospitals, but the two hospitals merged, resulting in a one-hospital town.

One of the advantages that I believe we will manage is what I call the disaggregating of interests. First of all, the doctors designed this hospital. They designed the plant; they will govern the hospital on a sixty/forty basis; and they will manage the hospital.

This new venture through the association with the very large Clarian operation, will get certain economies of scale, group purchasing advantages that a freestanding hospital could not hope for. In our case, and this would not apply to some other hospitals, there will be a bridge from the doctors in the clinic and in the hospital, to the school of medicine, and that is very important to them. There will also be a bridge from Clarian and the school of medicine to Purdue, and that is very important to us.

Finally, and most importantly, and this is what I am going to end on, there will be an alignment of financial, quality, and other such interests. These doctors, this ready-made medical staff, will have precisely the same interests that the hospital owner has in operating an efficient, high quality hospital, and in paying attention to the economic and market considerations that Professor Blumstein discussed in the first session of this meeting.

MR. PEMBERTON: Norm has shared one version of integration, the one that they are pursuing in a particular market. Steve Pratt will talk for a few mi-

minutes about other models for integration, short of total integration through ownership of a hospital.

MR. PRATT: First, I would comment that I agree with the problem as Norm Tabler has identified it, and I would add one point. In our health care system there is a disconnect between the authority to make decisions and the consequences of the decisions on the economic side. Physicians can make the decision to extend the length of the stay, order additional tests, and so forth, and the cost consequent to that is not borne by the physician at all. In fact, there might be a benefit to the physician, and I do not mean to be critical of physicians. I do not view it as a physician problem or a hospital problem. It is a structural problem. But that is a dynamic that we tried to change, and Norm Tabler has given one example, which is integrating through ownership, where we align interest through ownership of the facility.

Another model for a 501(c)(3) that does not want to do a new hospital, or a new facility of some type, is a contractual joint venture. The purpose of such a joint venture, for example, would be to manage a service line, for example a cardiac or orthopedic service line. Or you jointly operate an imaging center or an ASC as a distinct and separate approach to how you can collaborate with physicians; you then bring them to the technical side of medicine, the facility side, the hospital side, and have them work collaboratively with you as though it was a contractual joint venture. Moreover, there are limitations. It has to be a legitimate joint venture and ideally the physicians will have some legitimate business risk in the venture.

Now, the government has been critical of sham arrangements. These arrangements purport to be joint ventures when in fact, they are just an arrangement to get money to doctors when there is not much service being provided and no business risk being assumed. However, if your real purposes are to improve quality and efficiency of care, and if you have real services being provided, and ideally the physicians are taking some genuine business risks, I think you can use a contractual joint venture model as an alternative approach to create alignment.

I think the purpose for the venture has to be driven by a desire to make the health care facility a better place to receive care. By creating a better facility for physicians to give health care, you can improve the quality and the efficiency of the care received. One of the boundaries we work within, as do hospitals, is that we are not allowed to pay money to induce referrals. We are also not allowed to pay money to induce reduction of care, even if the care is not medically necessary. We are not allowed under the Civil Monetary Penalties Law to pay money if the purpose is to induce a reduction in care, even if in theory, that care was medically unnecessary.

It seems that there should be a process, a means for hospitals and physicians to work together to eliminate unnecessary, expensive care. I know one of the things that we wanted to talk about is an example of how a venture of this type has worked, and Dennis Pippenger was in management at Riverview Hos-

pital when they developed their surgery management company. One of the things we thought we would do is talk about how that happened, why that happened, and whether it has been successful.

Now, Professor Blumstein made some comments about studies that have shown that integration of this type perhaps does not create the economic benefit. We are going to give you an example today where it has.

DR. PIPPENGER: I have been in practice in Noblesville since the completion of my training at Methodist Hospital in 1979. In 1998 I was recruited by the hospital to become Vice President of surgical services and the medical affairs area. At that point in time, we were having some difficulties with the operations within the surgery department typical of many hospitals where there was no alignment of incentives, and people were not communicating properly. There were problems. Surgeons were unhappy. There was too much delay between cases and employees were not being responsive. It is not an unusual problem throughout hospitals. Additionally, other market forces, such as surgical joint ventures from other areas, put the hospital under pressure to come up with a better way of doing things.

The program that was developed was called Riverview Surgical Management Associates, otherwise known as RSMA, which is the management form of a joint venture. Basically, RSMA is a company that manages the surgical operations at the hospital. All the employees in the surgery department were hired by RSMA. They were no longer Riverview employees, giving them a direct link to the company and the ability to see who was running the show.

The company was comprised of equal membership, fifty percent owned by physician-surgeons and anesthesiologists, and the other half owned by the hospital. There was a board of eight people, four from the hospital, four elected from the physician-owners. The company then assumed all responsibility for the employees, human resources, case scheduling, and the ambulatory side where patients were admitted: the whole shooting match so to speak.

To make a long story short, it worked very well. It took a while to establish a new culture with the employees. The employees, I would point out, became incentivized financially. We had some incentives initially based on the number one. The highest incentive was on patient satisfaction, which was measured through a Press Ganey survey on a "likelihood to recommend" score. That was by far and away the largest incentive payment that came into the management company, and that employees participated in on the incentive side.

We also had an incentive for room turnover times, which was one of our problems. A budget was developed for that department. The ability to stay within the budget provided another incentive. The budget was derived through communications at the board level of RSMA. It was not just driven by the hospital anymore. We had physician input, indicating that there were problems with equipment not being there. The lack of equipment was slowing the processes down.

I believe the communications really solved a lot of problems for the phy-

sicians and the incentives worked very well. The employees understood what needed to happen, and the culture of the whole area changed. I think our “likelihood to recommend” scores were somewhere in the low eighty percent. I just happened to see, hot off the press from February 20th in the *Riverview Viewpoint*, a newsletter to the employees, that the ambulatory surgery area was awarded the highest score in the hospital, ninety-six percentile. Since RSMA took over, it is traditionally around ninety-two percent to ninety-four percent, so it went up considerably.

The patients are really benefiting from what has happened there. The surgeon-owners have driven the process to work and have seen to it that their colleagues, who may have not been part of RSMA, still enjoy coming to our hospital. The surgeons are much more efficient; there is not nearly the amount of wasted time. I think room turnovers went from about thirty minutes to about eight minutes between cases.

They have put in some new incentives lately. Administering antibiotics before surgery is one thing. It is recommended that prophylactic antibiotics be given within the hour prior to the start of the surgical procedure. Therefore, one of the incentives for bonus payment to surgical staff measures the time of administration of the antibiotic and it must be within the timeframe listed. This is an example of how incentive payments work toward compliance with best practices. This particular incentive was initiated to change behavior and provide for better patient care. The number of cases of noncompliance decreased to a very small percentage as a result of this strategy.

The Joint Commission has been interested in seeing that happen, so now that is measured. I think anything that you measure will improve. The Hawthorne effect, I think, is what it is called. We put a lot of measurements in place, and things have improved. It has worked very well. I did this for about six years and then went back into full practice again. The process and the culture continue under the current leadership.

MR. PRATT: I think one way to look at it is as Norm has described: actual ownership, you have equity in the venture. What we have tried to create through contractual joint ventures is something similar to virtual ownership. You feel, as a physician, a sense of accountability for scheduling issues, for nurse satisfaction issues, for the consequence of wasting supplies, things of that type. You do not have ownership, but you have a sense of responsibility and ideally a reward for fixing problems because of the virtual ownership.

MR. PEMBERTON: Steve Pratt, would you also just touch on some of the bigger legal issues that you wrestled with?

MR. PRATT: Norm Tabler hit on them at a high level; one is the laws that affect tax-exempts. We have to operate in a manner that serves the community. We have to ensure that we do not have too great a portion of our income from activities that are unrelated to our charitable purpose of giving

health care. The IRS is always watchful of what we do.

Another legal issue is the Stark law, which says if a physician has a financial relationship with a hospital or other provider, then that physician cannot make referrals to that facility, unless the arrangement can be structured to fit within a Stark exception. Like any good law it is riddled with exceptions, and there are exceptions to the exceptions, and it is a fascinating maze to work through, but it is one of the barriers that we face as we try to create relationships with physicians. We have to structure the arrangements to fit within a safe harbor.

We have talked a lot about the anti-kickback statute, which makes it a felony to pay money to induce a referral. It is a criminal law, so the point of proof is your mind-set: what did you intend? Thus, we are very careful to structure our arrangements to emphasize the good, lawful reasons that we are doing them; mindful that if one reason among many others is unlawful, if one reason of the hundreds that you are creating the venture is to induce a referral, it is unlawful.

Finally, the one statute I mentioned, the civil monetary penalty statute ("CMP"), says that a hospital cannot pay money to induce a reduction in care. This becomes a barrier when you are trying to work with physicians, for example, to manage supply costs, reduce staff costs, or to manage length of stay issues, because we cannot directly incentivize physicians to reduce those costs, which are hospital costs, by paying money. It would violate the CMP.

MR. PEMBERTON: If I can ask both Dennis Pippenger and Steve Pratt a question specific to this transaction? Riverview is a county hospital; it is a governmental hospital. I am really asking two political questions. First, how did you deal with large "P" politics in terms of a public institution entering into this new relationship? Was there any, or how did you manage any potential political fallout? Second, how did you deal with the internal political issues, in the sense that some physicians were in, some were not, and some were owners, some were not? So we're addressing the dynamics within the medical staff, what form of small "p" politics did you have to deal with, and how did you work through them?

DR. PIPPENGER: I think the small politics were the large ones for me with medical staff because there were a lot of hard feelings at the time. I think the people who went with the RSMA model recognized and understood that. I think our goal was to improve the operation at the hospital at Riverview because the other physicians invested in an outpatient facility, and we knew that they were still loyal and wanted to come with their inpatients and certain outpatient things as well. We wanted to create an environment that was welcoming and showed that yes, this is a different deal now, and it is a place that you will want to come to and you will enjoy the way business is going to be run.

I think the initial problems politically amongst the physicians disappeared because of the dramatic improvement in their environment. It is a place people

want to come to. It is a place where people would like to be employed, and as I showed, the statistics bear that out and everybody wins. Furthermore, I believe that when it is working well, it is a safer environment for the patients participating in the process as consumers.

On the larger political scale, this was something the hospital wanted. The hospital board members, who are appointed by the county commissioner, wanted this, so to that end, the large political side had been dealt with initially. I believe that the things that were promoted made sense to those people in the political arena. I suppose when you have a good outcome, there is not a whole lot of controversy.

MR. PRATT: I have always viewed it as there being three drivers that really allowed Riverview to do this. One is that there was a faction on the medical staff that was pulling away to do their own competing center. That split the medical staff and was a real threat to Riverview, so that enabled them to work with those physicians who were willing to create RSMA. In some senses, it was an alternative vehicle for what I will call the "friendly physicians," to remain at Riverview working, and performing their outpatient surgery there.

Secondly, it is a growth market, so management in a sense can afford to make some mistakes because if they misjudge the market, they will be able to catch back up due to the fact that it is still growing. This is not true in all communities. Sometimes you make mistakes on a significant strategic venture like this and it takes you a decade to recover. Thirdly, I think Riverview has always had good management, a good board, and good commissioners that let the board and management run the hospital. This is certainly not always true of county hospitals in Indiana.

I can think of another example with similar circumstances. An ASC was being formed by the unfriendly physicians on the medical staff. When the hospital responded, instead of finding a way to collaborate, they went to the commissioners who replaced board members, who then fired management. As this demonstrates, the politics are very serious at the county hospital level and it does not always turn out as favorably as it did for Riverview.

MR. PEMBERTON: Mike Finnerty, I want to drag you into this conversation. I think we will probably touch on some more examples that we have seen happening in the market, but could you take a couple of minutes and talk about the larger market forces? Mike's practice takes him on a national scale, which is very helpful in this regard.

MR. FINNERTY: It is interesting to stand back and take a more academic view of things, and Professor Blumstein's speech was fantastic in discussing several of the legal aspects that are driving some of these joint ventures. It took me back to the first transaction I worked on as a newly minted MBA. It was a physician practice acquisition, where we got a sixty physician practice group for the unbelievable price of thirty million dollars, \$500,000 a doctor, but

at the time it was all the rage.

In our practice, joint ventures fall into mergers and acquisitions ("M&A"), so I am in the M&A group, and we do that because we believe that joint ventures have a lot of transactional aspects to them, so that is probably what I am more prepared to talk about. A lot of the factors that were there when we were looking at those physician practice acquisitions are really emerging today, and we do look at a lot of the joint ventures somewhat skeptically.

Included in your packet is the White Paper that we wrote on joint ventures, and if you will notice, it is not overly encouraging of them. I think it is more matter of fact in that if it is something you are going to do, here are the best practices and here are the things you need to think about, because I think the jury is still largely out.

I think fundamentally what was driving physician practice acquisitions in the 1990s was a perception among physicians that they were not getting enough of the health care dollar, and in reality they are right. There was also hospital-to-hospital competition, which was all amplified by for-profits that were coming into this space; these for-profits were physician practice management companies, Phycore, Phymatrix. I think we were joking earlier that what would happen is one of them would fly in with their jet to the rural town. The hospital administrator would have heard about it within fifteen minutes, and then all of a sudden they were in negotiations to buy the practice in town, which is frankly what most of the physicians would have preferred over a for-profit company. The other one had a yacht, so if all your physicians left for a weekend to head to Miami, you knew you had some concerns. Additionally, you had for-profit hospitals coming into the market, and thus were confronted with the peer pressure, and the fear that they would be better able to partner with them and be more efficient.

Today across the country we have many of the same dynamics that we had in the 1990s. A lot of the joint ventures that you are seeing these days, particularly ASCs and image basing, are being enabled by outside for-profit companies. They are bringing the capital, they are the USPIs of the world. Some of them are hospital friendly, some of them are not. It is still a very fragmented industry and there is a lot of angel investing, and there is an awful lot of private equity in the sector. They will come with the management expertise, and will get a group of doctors together, particularly around the technology. We are doing a proton beam therapy in the southwest, and I cannot even really tell you what it is supposed to do, but it is hugely expensive. It is a for-profit company that came in and gave the hospital in town the unbelievable opportunity to invest in it. They had virtually no equity in this enterprise but were willing to jump-on it because they were worried about the competition. The fear of outside competition among hospitals is the second thing that I find that is still very, very prevalent.

There has been a tremendous amount of consolidation in the hospital industry nationwide. I believe in the past two years alone, our shop has worked on one side or the other of thirty hospital transactions. That is just unprece-

dented deal flow compared to the past few years. As those hospitals come together, you still have markets where it is the two behemoths or maybe even a third. A lot of times, you will see that the third hospital is willing to take risk. They will do some form of a joint venture, and there will be a competitive response. Even in this market [Indianapolis], there has been somewhat of a competitive response to the joint venture that is put together.

Still, it is not clear how fast or how much this is going to perpetuate. I think it largely depends upon the region. In the Paper that we handed out, you see that some hospitals and health systems are very proactive. We worked with Catholic Healthcare West to come up with a real methodology to evaluate joint ventures strategically, financially, economically, and operationally, and we have also developed execution guidelines. This is one end of the spectrum.

The second end of the spectrum is comprised of the hospitals that have either been approached by for-profit enablers, or someone else, and who come to them and say, "By the way, we are doing an ambulatory surgery center and if you play your cards right you can buy in for twenty percent." So those are the two ends of the spectrum that I think that you are seeing.

Across the country it varies to some degree. On the West Coast we are seeing a fair number of physician practice acquisitions that are much more financially disciplined. We are involved in two such acquisitions right now. They have a foundation model in California, which creates a lot more work for lawyers out there, and a lot of documentation, but it is gaining prevalence and the rating agencies are aware of it.

Not-for-profit hospitals, as you all probably know, are very concerned about their credit rating. They rely on not-for-profit or tax-exempt debt. The rating agencies have announced that they are aware and are watching it, but are not overly concerned about it. I anticipate that you are going to see a fair amount of that going on again, and it is not just in California. We just did one in Kentucky as well, so it really is largely across the country.

We are also seeing the typical joint ventures that you would imagine, mostly around ambulatory surgery centers, which seem to be far and away the largest segment of joint ventures going on right now. Professor Blumstein also mentioned these are largely being driven by reimbursement. Well, the jury is out on how that is going to go over time. There are a lot of rather innovative structures being employed to keep joint ventured ASCs treated as hospital outpatient departments as hospitals get paid more per surgery than a surgery center.

There are "under arrangements" and a number of other models that are designed to replicate hospital-based reimbursement in an ambulatory surgery center. It is then, somehow, shared through a joint venture with the physicians. The lawyers on the panel can slaughter my characterization when I am done, but that is largely the purpose of these structures and they are becoming prevalent.

We are also seeing acquisitions and/or recapitalizations of existing surgery centers. That is a very emotional one because a lot of times these surgery

centers have stripped out all the volume that they have from the hospital. After the surgery center owners have distributed everything that they possibly could, they have a lot of dead weight in the ownership structure and so now they want to recapitalize, and they come back to the hospital to do so. We have looked at approximately three of those in the last year and not one got finished. At the end of the day they just could not bring themselves to reward the physicians that had taken that volume ultimately out of their hospital.

More of what we are seeing is de novo development, and within that, the hospitals and health systems can be disadvantaged. There are those that are nimble. However, most hospitals like to borrow at an aggregate level because they have tax-exempt debt that they can avail themselves of, but the problem is if you pay cash for everything in an ambulatory surgery center. The returns, effectively to the physicians, can be less because you are not using leverage, and the buy-in can be more as compared to surgery centers facilitated by for-profit entities. I have been through many of these, where you get down to the end of the day and send out the subscription agreements and ask for checks and it gets really difficult, because physicians are strapped, their incomes are down, and they want to invest in other things but they do not want to take out second mortgages to do so. I don't think that is anything you can blame them for.

Outpatient imaging is another area that is very hot, but again, there are some proposed changes to reimbursement that make the future uncertain. Outpatient imaging is more dependent upon government reimbursement than outpatient surgery centers, so there is some concern as to how these ventures will fare in the long term. In this sector we have seen a variety of structures including the under arrangements model.

We are seeing some joint ventures that are rather interesting and less reactionary, less splitting of what exists and more going after the for-profits. That, from our perspective, is a lot of fun. It typically surrounds labs. The hospitals and larger clinics get together for tests that they actually receive reimbursement for, the real outreach business and going after the Quests and Lab Corps of the world. Some have been very successful, even on a super regional and national basis as a not-for-profit doing that.

One of the things that we have not really talked about is that, from an execution standpoint, joint ventures are amazingly complex. There are a lot of days you really prefer just a straight acquisition because in a business combination only one party survives effectively. In a joint venture there is three times the documentation. There are shareholder agreements, subscription agreements, and joint operating agreements. It is an awful lot more work from involving legal, management, and financial professionals in executing them, and these joint ventures are typically small from a revenue perspective. However, as I think as we have seen in the past, not doing joint ventures properly is very, very dangerous. It will be interesting to see the execution approach hospitals will take.

We remain somewhat unclear as to whether joint ventures will be the physician practice acquisitions counterpart for the 2000s. We just do not know.

Additionally, it does not take long for reimbursement methodologies and policies to change. Then all of a sudden you have a bad joint venture and the same physicians are increasingly finding themselves pigeonholed and come back to you saying "I want out of this." Therefore, saying we are cautiously optimistic is the best way to characterize our position on hospital-physician joint ventures.

MR. PEMBERTON: Thanks, Mike Finnerty. Norm Tabler, do you have a reaction to some of Mike Finnerty's points?

MR. TABLER: Well, I do. I think he made some great points. Two things that occurred to me are one, for years and years we thought that the competitive threat was bigger hospitals, combination of hospitals, mergers and acquisitions, but in virtually every one of the very excellent examples Mike gives, you can see that the problem for hospitals is really the opposite of that. The problem is that the business is being divided up into little pieces, some of them quite small. The little pieces are being taken away, whether it is laboratory, radiation, or high profit surgery, but the pieces are being taken away one at a time and that is both the competitive and financial threat.

It reminds me of something, which took me an embarrassingly long time to figure out. I think that really, the whole American hospital system is built on a theory, or foundation that has started to crumble. The foundation is that health care will be delivered through non-profit general hospitals. That is kind of an unexpressed assumption.

I say "general" because there are many lines of business that are back-breakingly unprofitable, such as the emergency room, but the theory is that all hospitals will be general and will take the bad with the good. I think you can make much the same case, maybe a little less compelling but still pretty compelling, that the theory of our hospital industry is that all hospitals will be non-profit and will have the same sets of duties and motives. I also think you can make a very compelling case that all structural beams of the hospital industry in America really depend on those assumptions, and they have proved to be fallacious. I will give you one example that I think gets much less publicity than it should, and that is the DRG system.

The DRG theory is that there will be a primary diagnosis and that the hospital will get paid a flat fee for that diagnosis. It is just like the guy with a book at the car repair shop. It shows what it ought to cost. That theory is completely dependent on the notion that hospitals will be general hospitals. If a forty-year-old man who is otherwise healthy has a heart condition, he may be treated at a heart specialty hospital. If he is eighty, has a lot of comorbidities, and his kidneys are worn out, the specialty hospital should not and will not admit him. They will send him to a general hospital, but the amount of revenue for the two patients may very well be essentially the same.

Well, you can see what is going to happen to the general hospital under that sort of program. It surely threatens the DRG system, and we cannot continue to operate under the DRG system as it is currently structured if specialty

hospitals are going to continue to proliferate.

QUESTION FROM THE AUDIENCE

MR. TABLER: The gentleman makes the point that if there are different payers, private versus public, that there will be a difference. That is often true, but it is very often not true, as well. It is true that there are technical adjustments in the hypothetical I mentioned, but my essential point is true. Generally, it is much, much more expensive to treat the kind of patients who need a general hospital than the kinds of patients who do not need a general hospital.

MR. PRATT: Norm Tabler is right. Up until very recently, a coronary artery bypass graft paid \$72,000. Medicare, recently, and in response to the pressure from specialty hospitals, and exactly the phenomenon Norm Tabler described, said we are going to begin to severely adjust that reimbursement. If you have a CABG (coronary artery bypass graft) surgery with comorbidities and complications, you will get paid \$82,000. If you have it without, you will get paid \$62,000, or some adjustment of that sort.

Medicare is responding to the marketplace, as always happens after the fact. They are changing the reimbursement to adjust for the severities, and thus are giving community hospitals greater reimbursements for more severe patients. While these adjustments have not been made in other areas, they are working on it in orthopedics and those areas where cases are pulled out of the general and into the specialty hospitals.

This is a phenomenon you see in health care. Whether it is physicians moving into imaging, to which Medicare notices, “gee, our imaging bills are climbing dramatically over a period of five years.” They then lower the outpatient imaging reimbursement and flatten the freestanding so that it is now comparable to hospitals. Part of what we do is stay one step ahead of those types of changes, because the government is always watching and once enough information comes in, they change how they reimburse. Whether it is to reimburse, to decrease reimbursement, to take away incentives, to move it out, or to increase reimbursement for high severity cases, and decrease it for low, it is a constantly evolving process based on the assumptions that Norm has described.

QUESTION FROM THE AUDIENCE

MR. FINNERTY: I will start off by telling you what we are seeing. Then someone with more experience can tell you what they are seeing, and whether or not they perceive it to be good. You know, there were many physician practice management companies. USON, US Oncology, was recently taken private, and it controls something like half, or some ungodly number of the oncologists in the country. Pediatrics is one of the few that survived. The practice management companies that manage simply multi-specialty practices have largely gone away and pediatrics and US Oncology, and a handful of other ones are

still out there managing contracts. They negotiate on behalf of their physicians, and their ability to leverage up against a hospital, I would leave to somebody else.

The second issue that we kind of think of separately is the emergency room doctors, and it certainly feels as though most physicians in the emergency room work for a for-profit company that contracts with hospitals to provide emergency room services, so it's definitely out there. We do not see them very acquisitive any more, but I would like to turn it over to Greg Pemberton.

MR. PEMBERTON: I will talk about the leverage question for a second at least. In the early 1990s, these companies were the darlings of Wall Street, and so all they had to do was grow and they could raise more capital. But the model disintegrated because once the management company had managed a physician practice anywhere from three to five years, they would run out of tricks and so they were not really returning the dollars to the physician-workers that used to be the physician-owners that they were before, and to great dissatisfaction.

Growth alone and accounting tricks were not enough to keep Wall Street happy, and so they really hit a wall. Phycore was probably the most famous one that hit the wall on all of this. They went away; the whole company pretty much went away. Now, the single specialty management companies have somehow weathered this. They are smarter about getting more tricks, or they are better with the accounting, or they are really good at what they do, or some combination thereof, but they seemed to have weathered it, and so that is a reaction from the ground.

MR. FINNERTY: Well, we have worked with US Oncology too. I mean, that is a practice that depends very highly on equipment very expensive equipment, and so, coming together and doing those services collectively, and providing kind of that expertise in reimbursement makes sense. Again, their physicians are very highly compensated. I think that is really the acid test in all of these things.

The other thing I would add to the Phycore discussion is that it just put the whole physician community in disarray for years. They were not just buying with cash, they were buying with stock. It just multiplied the Ponzi scheme, and so you found a lot of these doctors coming out. A lot of the for-profit hospitals look to not-for-profit hospitals to pick the practices up. It was very, very unsettling for some time.

MR. PRATT: Eleanor Kinney, on your question, one of the challenges I face constantly, whether it is in Indiana or other states, is exactly at that point. If I am the second guy in town to want to do the deal, the first guy that did it has locked them up with a non-compete that says you will not provide services to, have ownership in, or receive financial compensation from anybody else with whom I compete. It makes it very hard then to build either an equity mod-

el, an ownership model venture, or a contract joint venture type model because many of the doctors are forced to either take on the political risk of violating the non-compete, which they are not loathe to do, but they are afraid to do to some degree, or they cannot do it. I think that is somewhat inconsistent with the theory that underlies the nonprofit community-based hospitals: we are there to serve the community. We certainly have an obligation to remain financially healthy, but I believe that tying up your physicians with non-competes in a way that is good for you, but is not good for the community, is somewhat inconsistent with the theory behind being tax-exempt. Yet this happens all the time, and it is a real barrier to getting things done.

MR. PEMBERTON: We talked on the edge of an issue that I think we can coalesce, and put together yet another model for joint ventures that is short of ownership, and that is a participating bond transaction. This is relatively new to most of us, with the exception of one fellow who we all know pretty well has been peddling these around the country. For those in the audience that have never heard of a participating bond transaction, let me give you the primer on that. It is basically a tax-exempt bond offering which is made on a subordinate basis principally to the physicians who practice at the tax-exempt hospital. Through a series of agreements, or compromises, so to speak, the interest on the bonds proves to be somewhat higher than what would ordinarily be a tax-exempt bond rate.

In real numbers, where borrowings between four and five percent are in the market today for a tax-exempt AAA credit, you typically double that interest rate and are up in the eight, nine, and ten percent rate. On a tax-exempt basis that is pretty attractive when you convert that to what then translates to a taxable return. That is the high level about these transactions, and they are very complex. Mike was talking about costs of joint ventures; well, take this one, two, or three factors beyond that. It is much more cumbersome and challenging from a legal and financial perspective, and it can be very expensive. Transactional costs are way out of proportion for the amount of capital that you raise. And that assumes you can maneuver through a couple of fairly thorny legal issues to get there in the first place.

MR. FINNERTY: I would just say that I think we are doing one, and we are the financial advisor to one close by here. A handful of them have been done. One you may know better was challenged unsuccessfully, so it stood. Some have been unsuccessful and I believe there was one in Louisiana. In order to get through on the physicians' practice office exemption, some have been renting referring physicians both space and time on an imaging machine, such as an MRI. I cannot imagine that something which is solely designed to get you around the fraud and abuse is going to last in the long term. I also feel somewhat the same way about the participating bonds.

MR. PEMBERTON: Excuse me, my apologies. I left out a key point.

The reason they are called “participating” is because you only get paid interest if certain performance targets are hit.

MR. TABLER: Additionally, the interest can go up as the targets are exceeded.

MR. PEMBERTON: Correct. Performance targets are based on financial performance, quality, patient satisfaction, and several others. It is actually based on some of the same parameters that Dennis Pippenger mentioned in the surgery context, only now you apply it to perhaps, the whole hospital operation. Therefore, you have physicians who are bond holders and therefore are holders of the debt. This arrangement is attractive to them from a return perspective because they are going to help the hospital perform at the level necessary to hit the desirable targets, thereby enhancing quality.

MR. FINNERTY: Typically, we call that equity, not debt. That is the problem.

MR. PEMBERTON: That is what the IRS is concerned about, whether it is debt or equity.

MR. TABLER: We talked a lot about physicians as competitors with the hospitals, but if I had to list the ten biggest threats to our organization, I would say one of them would be the declining income of certain physician specialties. It is a terrible problem for hospitals because, say, we have one of the only two level-one trauma centers in the state, and in order to maintain our level-one certification, we have to have 24/7 access to all specialties. There are a lot of specialties that do not get compensated or reimbursed sufficiently to want to cover a downtown inner-city emergency room 24/7. Thus, we are looking for any means within the boundaries of the law to increase the compensation of those physicians.

MR. PRATT: To give you a real life example of that, when Indiana and other states went through this spasm of employing doctors, we were employing primary care doctors straight out of medical school at around \$120,000. That was a decade or more ago. I am employing them today for roughly the same amount. Physician compensation has been flattened in a way that is very harmful. I am working with one health system that has approached me and said “we have a sufficient number of primary care doctors in our community, but we will not in ten years because Medicare and other payers do not pay enough to keep them in family medicine, or to recruit new people who want to go into family medicine.” The hospital views this as a long-term problem for the community and the hospital. They need an adequate base of primary care doctors, and so they want to set up a program that will employ or otherwise subsidize physicians’ incomes.

MR. FINNERTY: In California that is a real problem because the cost of living is so high. It is certainly not the impetus for their foundation model, but it is very beneficial. They can establish a not-for-profit foundation. There are a number of hoops you have to jump through, but once you do, the hospital can then fund that foundation. The reality is the hospital looks at it as an acceptable loss level and then, in that way, they are able to bring physicians into the community. I was talking to the CFO at Cedars-Sinai and he stated that while they lose a lot of money, he believes it is more than reasonable because while they are not allowed to look at it, they do make it up in other parts of their business.

DR. PIPPENGER: I think that is a really important point. When we were interviewing hospital administrators a couple of years ago, we had a fellow from the county just north of San Francisco. Physicians cannot afford to live there. They had to commute about 100 miles just to come to work because they could not afford to stay in the city. That is just a reality in that area that is not so bad here. Truly though, this flat line of physician income has not just affected new grads. It has basically been a problem for almost all physicians, other than a few in certain specialties that have done well because of the things we have talked about. However, the question was "what does that do to the practice of medicine in the future," and my answer to that is I do not know. The laws and regulations are constantly evolving, and we must move with the changes and challenges. Joint ventures are a means of addressing this conundrum. While hospitals have been doing seemingly well, physicians have not. The last ten years have been bad for physicians as a whole, and I believe it is becoming more difficult to find a primary care physician due to these issues.

MR. PEMBERTON: Next topic. Let us go back to something that Professor Blumstein mentioned, but not by name. He talked about the gain-sharing arrangements that the federal government is exploring. I want to talk about another federal and also private phenomena that I think we see on the horizon. I think it relates to physician-hospital relationships. I am speaking of the pay-for-performance phenomena, and the reactions to some of the model programs that the government and some private insurers are doing. Will it work? Is it a good trend? Is there enough money for it to matter? What are your reactions to just the whole pay-for-performance phenomena?

MR. TABLER: I have to say that it really does frighten me. I do not think of myself as a cynic, but in most of the models that I have studied carefully, including some that we got close to executing, I think there is a terrible risk that the performance that you pay for is, by and large, the performance you would have received anyway. Let me use a homely example. Let us say your office hours for clerical staff are eight to four. What is wrong if you decide to give a bonus to everybody that actually shows up at eight o'clock? Well, what is wrong is a lot of people already show up at eight o'clock, and now you are

going to pay them bonus for that? I see a profound risk of that in the operation of a hospital.

MR. PEMBERTON: Other reactions?

MR. PRATT: I agree. You have to be careful on the criteria you settle upon as a basis for payment. If you look at some of the gain-sharing arrangements that have been approved, they are an attempt to align incentives. An example is paying your cardiologist not to open instrument packs unless they are going to use them. The hospital made the case that their surgeons routinely opened instrument packs and often did not use them during the procedure, but it resulted in a \$50 or \$100 cost per pack to the hospital to re-sterilize, reseal, and prepare them for the next procedure. It also meant you have to have more instrument packs available, so more capital is tied up. Thus, the hospitals have made the case to the government that they should be able to pay them an incentive not to do that, to change their behavior. Whether you should have to pay for that is a legitimate point for debate, but without paying for it, you do not get the behavior you want.

I often arrange contractual joint ventures, the purpose of which is to improve some efficiencies and for example, to pay for on-time starts. If you start your first case of the day late, every case of the day is late and you are going run into overtime, which runs into significant staff costs for the hospital. So the question becomes, can we set up a program that rewards doctors for showing up on time? Can we reward them for actually using the blocked time that they reserve so that we are not in a position that the doctor has the room reserved from eight to eleven? They show up at nine and they do their last case, finishing at 10:15, leaving us with an hour-and-a-half-plus of unused operating room time, staff time and so forth. Well, whether we should have to pay for that or not is a debate, but without paying for it, we do not the get the behaviors we want. If there is no reason to behave, you don't get the behavior. I think you have to acknowledge that and move forward with programs like this that will work to change behaviors and create an alignment.

MR. PEMBERTON: Well, presumably in the public sector, if it is the government pushing pay-for-performance, they can take other laws that might be impacted and sort of sweep them away to make it work. What about the private sector? What if a large unnamed health insurer that is headquartered in Indianapolis were to put forward a pay-for-performance program and there are legal and ethical concerns? How do you wrestle with those as a physician, a lawyer, or as a business person?

MR. PRATT: My view is that there are ethical concerns in all of these because you don't want to pay to give the patient less. The purpose should be to provide the care that is needed, but to do so in an efficient manner. There certainly are fewer legal constraints. Most of what we struggle with in creating

these programs is the restrictions imposed by Medicare, CMS, or CMS patients. I have not really worked through an Anthem, United, or Sagamore plan like that. There would be legal considerations, but I have to say I think it would be much easier if you are only dealing with a set of commercial lives.

MR. TABLER: We do have, what you might fairly call, pay-for-performance arrangements with some unnamed gigantic payers here in Indianapolis. We have enormous amounts of money dependent on meeting certain quality goals. We have not encountered any issues to date. One technical, but I think significant consideration that has to be addressed, which could apply to Steve Pratt's excellent hypothetical just now, is what about improvements after year one? How do you get better in year two, let alone year three? If you do not get better, do you still give the incentive?

DR. PIPPENGER: I think you need to change the incentives to what is appropriate at the time. That is what we do, although we still maintain patient satisfaction as one of the largest incentives by far.

MR. FINNERTY: But in some senses, is it not a rebasing? That is what a lot of people are concerned about. The buzz on pay-for-performance from CMS is that right now it is only a carrot, but pretty soon, it will be a stick. Right now you get eighty percent of your compensation if you show up an hour-and-a-half late for your first surgery, and you get 100% or 110% if you are on time, whatever it happens to be. I wonder if it is just going to be a change in how compensation is done in the future.

MR. TABLER: One thing I always think about when people bring up the ethical issue, is that it seems funny to nibble around the edges of that ethical issue when, certainly on the procedural side, the physician can decide whether to recommend the procedure and to perform the procedure, and you trust the surgeon to do the right thing. Thus, it seems like haggling over pennies to wonder whether the fact that a few extra bucks are dependent on this pay-for-performance program is ethically offensive.

QUESTION FROM THE AUDIENCE

MR. TABLER: I really think that the ethical concern raised is exaggerated. I think it is the monster under the bed that is not really there. First, put aside the fact that every industry in the United States is operated on the employment model that is being hypothesized. Secondly, remember that if you talk about the physician being an employee of the hospital, then you are asking is there an ethical problem in the fact that this doctor has an indirect financial interest as the employee of the hospital. However, the status quo is that he has a direct financial interest because if he recommends and delivers care, he gets paid directly. We accept that much greater ethical conflict than we do the pro-

posed employment model.

QUESTION FROM THE AUDIENCE

DR. PIPPENGER: I think the pressure for that [taking into account pay-for-performance initiatives and reimbursement when making medical decisions] is already there. At least at our hospital, the standard of care would suggest that you always use those measures. If something unfortunate happens and the standards have not been followed, then there are going to be consequences. Thus, your decision making is influenced by those kinds of things, and doing what is right. I think it becomes pretty clear to you that way. If somebody wants to pay us more for doing what we are already doing, that would be fine.

QUESTION FROM THE AUDIENCE

MR. PEMBERTON: He has stated that joint ventures appear to be successful when there is a predominately private payment source. What happens if in the future, we are at a single-payer system or something along those lines; will joint ventures go away?

MR. TABLER: Well, I think essentially they are equally attractive whether it's a public or private payer.

MR. PRATT: I do not think they will go away. There is always going to be a need to have the physicians and hospitals working toward the same goal of being efficient in providing quality care, whether that is a single-payer system or the system we have today.

MR. PEMBERTON: Since it is early in 2007 and next year is an election year, let us talk about health care reform. I think it is fairly likely that health-care is going to be a huge issue in the presidential election of 2008. Regardless of what candidate gets nominated and elected, there is going to be dialogue. What kind of fallout would the panelists predict, based upon this spotlight of health care reform that employers, unions, everyone seems to be concerned with today?

MR. PRATT: Well, I'd offer one observation and that is there will certainly be reform that is designed to reduce costs.

MR. TABLER: Well, I think we are moving inexorably toward a one-payer system. If you would look at our books, and aggregated Medicare and Medicaid, you would think essentially we were in a virtual one payment system. I have a suspicion that a fair amount of the public assault on the hospital industry and health care costs from governmental spokesmen is really intended to soften the population up for a one-payer system.

MR. PRATT: For those of you not in health care, Norm Tabler said that at Clarian it is roughly fifty percent government payment. I think that is fairly typical. Forty, to fifty, to sixty percent government revenues are common for a hospital if it is a full-service hospital.

MR. TABLER: Moreover, it is going up, and it would go up even if no changes in the system were made at all because everybody is getting older. As the gentleman who asked the question reminded me, everybody is getting older and thus using more of Medicare. Additionally, there is a pretty strong phenomenon, although I do not know whether it is permanent or not, but the increasing number of uninsured is another way of saying that we are experiencing an increasing number of Medicaid patients.

MR. PEMBERTON: Many of the reform discussions start with the idea of extending either Medicaid on a state level, or Medicare on a federal level to other populations. For example, Medicaid has the SCHIP's program and things along those lines, where you extend the eligibility to cover a larger body of folks, and incrementally get to a single-payer system.

MR. FINNERTY: I remember Hillary Clinton and Ira Magaziner getting together to reform health care; probably right when I was getting out of college. The thing that I find interesting is that across the country, states are increasingly going to for-profit companies to manage their Medicaid business. We are also seeing a real resurgence in Medicare that is being shipped out to for-profit insurance companies. They are even going out now to PPO plans for Medicare, so I guess anything is possible. You know, you have basically given them fifty percent of the dollar and they made a mess of it. Now they are saying if you give us the whole thing we can really make this work, and I do not know how that is going to fly at the end of the day.

MR. PEMBERTON: You wouldn't be a free marketer, by any chance?

DR. PIPPENGER: I was rather hopeful that there would be a big debate on that two or three years ago, but I think other things took precedence at that time, so I look forward to that. I hope that that does become the top issue of 2008. I, for one, think the current system is headed toward total disaster and something has to happen sooner rather than later. I think if we had a one-payer system that would simplify things a lot. Each company has different forms, and complications arise with everyone using different software, and all in all, it's just a nightmare to work through.

I believe it may come down to just a single-payer system, or perhaps a two-tier system, whereby perhaps you have some form of supplemental insurance, but at the very least, everyone would be able to have a doctor or coverage of some type. I think that is where we're headed.

MR. TABLER: I am not prepared to do it right now, but I think you could make a fairly compelling case that health care is too important for the government not to provide it. That it is so fundamental, it is like police protection, fire protection, military defense, streets and highways. The only way to do that for everyone in a reasonably effective way is to do it through the government. Education is another one of those fundamental services.

MR. PEMBERTON: Once we have a single-payer here in Indiana, then we will sell it to somebody from Australia.

QUESTION FROM THE AUDIENCE

MR. PEMBERTON: This is not an answer, but it is one factor to take into account as to what might bring about change, and that is what the health care system is continuing to do to our competitiveness on an international scale. If our workers cannot be insured and we cannot afford their health care, it is causing prices of our products to continue to go up. That may be finally when the chamber of commerce and the unions all of a sudden hold hands and say, "this has got to change and Congress you got to do it." That is when I believe something is going to happen, when you have everybody that employs somebody saying, it is got to change, and you have got everybody that is employed saying it has got to change.

MR. TABLER: Well, I agree with what the questioner said. I think the system is fundamentally broken and needs a fundamental fix.

