Besides Being a Good Radiology Group, Are We Doing Everything We Can Be Doing?

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DISCLOSURE

NONE

Introduction

- Why do we care?
- What can we be doing?
  - Exclusive provider agreement.
  - Co-management and other relationships with hospitals.
  - Directly competing for teleradiology business.
    - As an individual group.
    - As part of a regional or national network.
  - Participation in clinically integrated networks (“CINs”) and accountable care organizations (“ACOs”).
  - Mergers involving radiology groups.
  - Conversion of imaging centers/joint ventures to provider-based or under arrangement.
  - Broader market-wide roll-up joint ventures for outpatient imaging.
  - Outright sales of imaging centers or joint venture ownership.
  - Affiliate with a physician practice management company (a “PPMC”).

Why Do We Care?

- Perhaps at no other time in history has health care, particularly radiology, experienced the recent volume and velocity of change.
- The drivers:
  - Health care "reform."
  - Federal scrutiny of diagnostic imaging.
  - Reimbursement pressure from all governmental and non-governmental payors.
  - More and more (expensive) technology.
  - Heightened tension with hospitals and their efforts to acquire physician practices (even radiology groups).
  - Accountable care organizations, as well as other integrative efforts, most often being driven by hospitals.
  - "Big" teleradiology businesses and PPMCs are changing the competitive landscape for professional radiology services.

Exclusive Provider Agreement

Things to think about at the outset

- Consider . . .
  - How valuable is your radiology group to the hospital?
  - Would it be viable for the hospital to replace your radiology group?
    - How much short term “pain” is the hospital willing to suffer?
  - Is the hospital seeking to employ most/all physicians?
  - How confident are you in your answer to these questions?
  - How much risk are you willing (or do you need) to take in your discussions with the hospital?
- . . . and how much leverage do you have?
  - How “good” or “bad” your exclusive provider agreement ends up will depend on how much leverage you have.

Advantages

- Radiology group is granted exclusive privileges to read diagnostic imaging procedures.
- Respective rights and responsibilities of the radiology group and the hospital can be clearly articulated.
- Presents an opportunity to negotiate for radiology director and co-management fees, compensation for coverage, financial support for teleradiology, and other reimbursement not previously provided by the hospital.

Advantages (cont'd)

- Can create a modicum of security (depending on the termination provisions), at least in the near term.
  - And may be useful when recruiting new radiologists.
- Can build in a mechanism to resolve disputes (short of medical staff membership termination).

Advantages (cont'd)

- Sources of past conflicts can be addressed.
- If the hospital has hinted that it might be considering an employment relationship for the future, an agreement would allow the radiology group to address whatever is driving the hospital:
  - Integration.
  - Risk-based contracting.
  - Tangible commitments related to performance.
  - Competition in the future.

Disadvantages

- What is “exclusive” is all in the eyes of the beholder.
- And the *quid pro quo* for whatever exclusive privileges are granted may be a “clean sweep” provision, *i.e.*, if the agreement is terminated, medical staff membership is terminated without any due process rights.

Disadvantages (cont'd)

- The agreement may impose far more detailed and burdensome obligations on the radiology group.
  - "Performance standards."
  - Limitations on the use of *locum tenens* and other independently contracted radiologists.
  - Expansive medical director responsibilities.
  - Mandatory participation in payor contracting.
  - Covenant(s) not to compete for technical component ("TC"), and possibly for professional component ("PC").

Disadvantages (cont'd)

- More generally, in this world of accountable care organizations ("ACOs") and OWAs aimed at integration, hospitals are looking to exert more control over their radiology groups.

Disadvantages (cont'd)

- The hospital may seek to make each of the radiologists personally liable on certain (or all) of the provisions of the agreement.

So, what's the answer?

- If you don't currently have an exclusive provider agreement, think twice before asking for one.
  - Once you ask for one, it may then be difficult to decide you don't want one (and the hospital will likely insist on preparing the first draft).
- If the hospital initiates and presents you with an agreement, carefully weigh the advantages and disadvantages.
- Think about what you can accomplish by entering into an exclusive provider agreement (and what you cannot accomplish).

And if all else fails . . . Be aggressive!

- Prepare for asymmetrical, guerilla warfare.
- Conduct a multi-channel PR campaign.
  - Remember to comply with any existing confidentiality obligations.
- Engage in Kissinger-like shuttle diplomacy.
- NEVER underestimate the value of a medical staff that values and appreciates the quality and service of the radiology group.
- Always remember: it ain’t over ‘til it’s over!
- But also: it ain’t finished ‘til it’s finished!

Co-Management and Other Relationships with Hospitals

Why Consider Other Relationships with Hospitals?

- As noted above, radiology groups are increasingly experiencing heightened tension with hospitals and hospital efforts to acquire physician practices.
- On the other hand, the hospital might be the last/best option for staving off potential downward trends in a radiology group and for thereby surviving into the future.
- And despite anecdotal evidence that is replete with stories of hospitals' indifference towards radiology groups, many hospitals recognize the value of their radiology groups within the care continuum and don't want to see their radiology groups fail.

How Can Radiology Groups Help Hospitals/Obtain Help?

- If a radiology group needs to find other ways to “integrate” with the hospital, and new income sources for the group, then consider:
  - Co-management agreements.
  - Medical director agreements.
  - Coverage agreements.
  - Recruitment support.

Directly Competing for Teleradiology Business

Teleradiology As An Individual Group

- For some groups, directly competing for teleradiology business means developing the requisite infrastructure for full distributed radiology (“DR”) within the group and the locations served by the group.
  - This will often mean involving the hospitals in some way.

Teleradiology As An Individual Group (cont'd)

- For other groups, this means much more than just internal DR.
- These groups use their teleradiology capabilities not merely as a productivity tool within the group.
- Instead, they use teleradiology to acquire new customers and capture market.
- Many of these groups remain focused on a relatively narrow, immediate geographic area.

Teleradiology As An Individual Group (cont'd)

- And then there are other groups that refine their teleradiology capabilities to the point that they look and act very similarly to the big, investor-owned teleradiology companies.
- These groups often aggressively seek new customers from across the country (and from overseas).

Teleradiology As Part of a Network

- Some radiology groups are forming “regional,” two-group or multi-group networks to:
  - Support internally each other’s teleradiology efforts.
  - Provide other infrastructure.
- In some instances, hospital systems “hint” to radiology groups that the groups should find some way to work together so that the system only has to enter into a single exclusive provider agreement for all of its hospitals.

Common Objectives

- These deals usually provide official reads.
- They allow the radiology group to compete more effectively with other radiology groups and with teleradiology businesses.
- Each radiology group is better positioned for hospital mergers and hospital-related integration (physician practice acquisitions).
- In general, these deals enable the radiology group to compete for more patients and non-patient customers.

CINs and ACOs

Why Participate?

- CINs are often being driven by local payor demands for integration and risk-based compensation.
- ACOs are creatures of Medicare, and although they are really just a form of gainsharing, “ACO ver.2” will likely involve risk, and is clearly where Medicare would like to get to.

Why Participate? (cont'd)

- One question for radiology groups, that requires you to pull out your crystal ball, is how long is it going to take the major payors within your market (as well as Medicare) to move significant portions of their beneficiary population into CINs/ACOs.
- Another question for radiology groups is how much authority are you willing (or feel forced) to cede to the CIN/ACO (which is often itself largely being driven by the hospital)?

CIN/ACO Participation: Think/Act Like an Investment Banker

- Understand the policy objectives and operational requirements of CINs/ACOs.
- Figure out how the patient care (and the resulting reimbursement) is going to flow, what the various costs and benefits are, where the real value propositions will be found (clinically and economically), and, how the radiology group can impact and participate in these value propositions.
- Be proactive to the extreme; get involved.
- Diversify: consider consolidation strategies to better position the radiology group for participation with one or more CINs/ACOs (assuming your hospital will allow this).

Mergers Involving Radiology Groups

This Afternoon:

"Thoughts from a 'Premarital Counselor' on How to Have a Successful Marriage (Merger)"

Conversion to Provider-Based or Under Arrangement

Some Medicare Vernacular

- Physician groups, including radiology groups, and independent diagnostic testing facilities ("IDTFs") are considered to be "suppliers" by Medicare.
- Hospitals are considered to be "providers" by Medicare.

Why Convert?

- DRA 2005 reduced technical component TC reimbursement for suppliers.
- Multiple procedure discounts under Medicare has also reduced reimbursement for suppliers.
- Non-governmental payor reimbursement to suppliers has followed Medicare down, either automatically (through fee provisions) or by negotiation.

Why Convert? (cont'd)

- By contrast, providers very often receive reimbursement from non-governmental payors that is significantly higher than what suppliers receive.
  - Note that conversions are not being driven by Medicare: DRA 2005 in effect equalized outpatient reimbursement for suppliers and providers.
  - Rather, it's the advantages for providers on the nongovernmental side that's the big driving force.
- **QUERY**: how long lived is the arbitrage opportunity?

Why Convert? (cont'd)

- Everyone is looking for ways to squeeze out additional revenue and profit/margin.
- A conversion to provider-based or under arrangement can make this happen.

Factual Scenario

- Existing hospital/radiology group joint venture, enrolled with Medicare as either an IDTF or a diagnostic radiology group practice clinic ("DRGPC"), is converted to provider-based or under arrangement.
- Variation: a hospital could buy partially into a center owned/operated by a radiology group (or other entities/persons), and then the resulting joint venture is converted.

History and Purpose of Provider-Based Rules

- Why they were promulgated.
- They are rules of exclusion, not rules of inclusion.
- They specify the requirements that must be satisfied in order for a facility or organization to be treated as part of a main provider.

History and Purpose of Provider-Based Rules (cont'd)

- "Provider-based" is a Medicare enrollment concept, so why even worry about it if conversions are being largely driven by non-governmental reimbursement?
- The answer: because it's very difficult, if not impossible in most instances, to have a facility operate as a provider for purposes of non-governmental payors while being operated as a supplier for purposes of Medicare.
  - State licensure and certificate of need ("CON") limitations.
  - Payor contract requirements.
  - Operational burdens.
- So if you want to be reimbursed like a provider by non-governmental payors, you're probably going to need to find a way to be reimbursed as a provider by Medicare.

What If a Joint Venture Will Be Involved?

- If on-campus of the main provider, then may be able to qualify under the provider-based rules.
- If off-campus, cannot qualify under the provider-based rules
- An alternative for off-campus, joint-ventured facilities or organizations may be the under arrangement rule.

Under Arrangement

- Receipt of payment by the billing provider (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment made by Medicare must discharge the liability of such individual or any other person to pay for the services.

Under Arrangement (cont'd)

- The billing provider must exercise professional responsibility for the services obtained under arrangements:
  - Apply same quality controls over under arrangements personnel.
  - Apply its standard admission policies.
  - Maintain a complete and timely clinical patient record.
  - Maintain liaison with under arrangement entity's attending physician.
  - Ensure that medical necessity is reviewed on a sample basis.

Provider-Based *v.* Under Arrangement

- Be aware that:
  - Any facility or organization that furnishes ALL services under arrangements cannot qualify as provider-based.
  - Providers cannot contract out entire departments under arrangements while claiming them as provider-based.

Provider-Based *v.* Under Arrangement (cont'd)

- But the big distinction is . . .
  - Provider-based facilities or organizations are not required to satisfy the under arrangement requirements, on the other hand . . .
  - CMS has given mixed signals on whether facilities from which services are obtained under arrangements must satisfy the provider-based requirements.
    - At a minimum, CMS likely will look at the nexus between the joint venture and the hospital.

Provider-Based v. Under Arrangement: The Choice

- If on-campus, convert to provider-based.
  - Radiology group will need to understand fully and make sure that it is comfortable with the provider-based requirements.
- If off-campus, convert to under arrangements.
  - Again, the radiology group should fully understand and be comfortable with the (less burdensome) under arrangement requirements.

Roll-Up

Factual Scenario

- Existing provider-based outpatient imaging centers, owned by one or more hospitals, and existing IDTFs, DRGPCs and/or other supplier-based imaging centers (owned by one or more physician groups or other entities/persons) are contributed into a new joint venture.
- In return, the previous owners become new owners of the joint venture *pro rata* to value of centers (and any other assets/cash) contributed.
- Joint venture then operates the centers post-closing as provider-based or under arrangement.

Roll-Up Considerations

- Generally the same provider-based v. under arrangement analysis.
- However, a roll-up will inherently involve multiple centers thereby making it much more likely that some centers may be on the campus of the main provider while others will be off-campus.
- As a result, the joint venture may be able to qualify certain centers as provider-based and operate the other centers under arrangements with the main provider (or possibly even as IDTFs).

Outright Sale of Imaging Center or of Joint Venture Ownership

Factual Scenario

- Hospital acquires existing IDTF, DRGPC or other supplier-based imaging center (*e.g.*, from a radiology group or a self-referring physician group).
- Hospital then operates the center post-closing as provider-based.
- Variation: The acquiror is someone other than a hospital.

Sale Considerations

- Assuming the center is located with 35 miles of the hospital's campus, the hospital should be able to qualify the center as provider-based.
- If off-campus, there will be significant limitations on the types and levels of administrative and management services that the hospital can contract out for, *e.g.*, to the radiology group.
- And you will encounter all of the typical issues faced when selling a business.

Physician Practice Management Companies

What's a PPMC

- Not necessarily a new phenomenon for radiology, but one seeing a resurgence.
- Often investor-owned.
- They usually want to "own" the radiology group, and "buy" an income stream.
- They can then use "their" radiology groups to compete for business using teleradiology.

Key Issues

- What's the deal that's on the table?
  - Initial and then ongoing?
  - Economics?
  - Tax considerations, particularly as they pertain to the initial "sale."
- Critically important to "connect the dots."
  - The interplay of all of the documents and all of the moving parts of the arrangement, on a going forward basis, can disguise somewhat insidious consequences for the radiologists.
  - So, put it all together and understand exactly what you're agreeing to and what the potential consequences are.

Conflict with Your Hospital

- When you do a deal with a PPMC, you likely, in effect, give up any meaningful control of the radiology group, and . . .
- The PPMC's interest may not be aligned with the interest of your hospital, so . . .
- What happens if a conflict develops between your hospital and the PPMC?

Thank you!

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