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Provider-Based, Under Arrangement, Sale or Roll-Up: Alternatives for Restructuring Imaging Centers

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Disclosure:

NONE

Introduction

- "The lay of the land."
- Provider-based *versus* under arrangement.
- Sale.
- Roll-up.
- NOTE: will not discuss ventures involving referring physicians.

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.

"The Lay of the Land"

- DRA 2005 reduced technical component ("TC") reimbursement for suppliers, making it harder than ever to run a profitable outpatient imaging center.
- Non-governmental payor reimbursement to suppliers has followed Medicare down, either automatically (through fee provisions) or by negotiation.

"The Lay of the Land" (cont'd)

- By contrast, providers very often receive reimbursement from non-governmental payors that is significantly higher than what suppliers receive.
  - Note that restructurings 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.

"The Lay of the Land" (cont'd)

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

"The Lay of the Land" (cont'd)

- Providers may have strategic reasons for restructuring, buying or rolling up imaging centers:
  - Outreach into the community to provide a better, more expansive continuum of care.
  - Compete with other providers (*e.g.*, moving into a competitor's "back yard") *and/or* eliminate a competitor.
  - Attract referrals from physicians.
  - Create more effective and efficient coverage and service relationships with radiology groups.
  - Develop more optimized technology investment.
  - Simply deploy available capital (some have strong balance sheets) to exploit the effects of changes in the market.
  - Build for a future under accountable care organizations.

"The Lay of the Land" (cont'd)

- Suppliers may have many of the same strategic reasons.
- In addition, radiology groups are constantly looking for ways to better ally themselves, and strengthen their relationships, with their hospitals.
- Some radiology groups need to find new income sources for the group (such as coverage agreements, co-management and/or medical director agreements, and recruitment support), and these may be easier to obtain as part of a restructuring, sale or roll-up.
- But in the end for some suppliers today, a restructuring, sale or roll up of the imaging center may present the last, best hope for the center's survival.

Factual Scenario No. 1: Conversion to Provider-Based or Under Arrangement

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

Factual Scenario No. 2: Sale

- Hospital acquires existing IDTF, DRGPC or other supplier-based imaging center (*e.g.*, from a self-referring physician group).
- Hospital then operates the center post-closing as provider-based.

Factual Scenario No. 3: Roll-Up

- 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.

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 restructurings, sales and roll-ups 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.

On-Campus *v.* Off-Campus

- There are fewer requirements to qualify as provider-based if the facility or organization is located on the campus of the potential main provider.
- "***Campus*** means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual basis, by the CMS regional office, to be part of the provider's campus."

Provider-Based Requirements Applicable to On-Campus AND Off-Campus Facilities or Organizations

- Licensure.
- Clinical integration.
- Financial integration.
- Public awareness.
- Fulfill specified obligations of hospital outpatient departments.

Additional Provider-Based Requirements Applicable ONLY to Off-Campus Facilities or Organizations

- Operation under the ownership and control of the main provider.
- Administration and supervision.
- Location
  - Generally no more than 35 miles from the main provider and in same state or adjacent state when consistent with the laws of both states.
  - Other, narrow ways to satisfy location requirement.

Provider-Based Status for Joint Ventures

- The facility or organization must:
  - Be partially owned by at least one provider,
  - Be located on the main campus of a provider who is a partial owner,
  - Be provider-based to that one provider whose campus on which the facility or organization is located, and
  - Meet all requirements that are applicable to BOTH on-campus and off-campus facilities and organizations.
- As a result, off-campus joint ventured facilities or organizations *per se* cannot qualify under the provider-based rules.

What If a Joint Venture Will Be Involved?

- If on-campus, 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 *versus* 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.

So What Are the Options?

Factual Scenario No. 1 Revisited: Conversion to Provider-Based or Under Arrangement

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

Factual Scenario No. 1 Revisited: Conversion to Provider-Based or Under Arrangement (cont'd)

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

Factual Scenario No. 2 Revisited: Sale

- Hospital acquires existing IDTF, DRGPC or other supplier-based imaging center (*e.g.*, from a self-referring physician group).
- Hospital then operates the center post-closing as provider-based.

Factual Scenario No. 2 Revisited: Sale (cont'd)

- 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.

Factual Scenario No. 3: Roll-Up

- 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.

Factual Scenario No. 3: Roll-Up (cont'd)

- Generally the same analysis as for factual scenario no. 1 above.
- 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.

Other Provider-Based/
Under Arrangement Considerations

Supervision of Hospital Outpatient Diagnostic Services

Supervision of Hospital Outpatient Diagnostic Services

- What the "old" rule was perceived to be.
- The objective of the new rule: to conform the supervision requirements for hospital outpatient diagnostic services as much as feasible with the requirements for such services when reimbursed under the Medicare Physician Fee Schedule (*e.g.*, services provided by physician groups and IDTFs).
- Effective date of January 1, 2010.
- See Program Transmittal 128, Change Request 6996, dated May 28, 2010, and effective July 1, 2010.

Supervision of Hospital Outpatient Diagnostic Services (cont'd)

- All services subject to general, direct or personal supervision.

Supervision of Hospital Outpatient Diagnostic Services (cont'd)

- For services furnished directly or under arrangement in the hospital or in an on-campus outpatient department of the hospital, "direct supervision" means the "physician must be present on the same campus and immediately available to furnish assistance and direction throughout the performance of the procedure."

Supervision of Hospital Outpatient Diagnostic Services (cont'd)

- For services furnished directly or under arrangement in an off-campus outpatient department of the hospital, "direct supervision" means the "physician must be present in the off-campus provider-based department of the hospital and immediately available to furnish assistance and direction throughout the performance of the procedure."

Supervision of Hospital Outpatient Diagnostic Services (cont'd)

- In neither instance does direct supervision "mean that the physician must be present in the room when the procedure is performed."
- "Immediate availability requires the immediate physical presence of the physician."
- CMS has not defined "immediate." However:
  - If a physician is performing another procedure or service that he or she could not interrupt, then that physician could not be immediately available.
  - And "for services performed on-campus, the supervisory physician may not be so physically far away on-campus from the location where hospital outpatient services are being furnished that he or she could not intervene right away."

Supervision of Hospital Outpatient Diagnostic Services (cont'd)

- "The supervisory physician must have, within his or her State scope of practice and hospital-granted privileges, the knowledge, skills, ability, and privileges to perform the service or procedure. Specially trained ancillary staff and technicians are the primary operators of some specialized diagnostic testing equipment, and while in such cases CMS does not expect the supervisory physician to operate this equipment instead of a technician, the physician that supervises the provision of the diagnostic service must be knowledgeable about the test and clinically appropriate to furnish the test."
- "The supervisory responsibility is more than the capacity to respond to an emergency, and includes the ability to take over performance of a procedure and, as appropriate to the supervisory physician and the patient, to change a procedure or the course of care for a particular patient. CMS would not expect that the supervisory physician would make all decisions unilaterally without informing or consulting the patient's treating physician or nonphysician practitioner. In summary, the supervisory physician must be clinically appropriate to supervise the service or procedure."

Supervision of Hospital Outpatient Diagnostic Services (cont'd)

- Query whether only radiologists are qualified under the preceding language?
  - Supervision of diagnostic services still can only be provided by physicians, but we do NOT believe only radiologists are qualified.
  - CMS could have used the IDTF regulatory language which requires supervising physicians for IDTFs to be "proficient in the performance and interpretation" of the test.
  - We do believe that hospitals need to review the clinical qualifications of the supervising physicians and put them through some type of "quasi-credentialing" process.
- And don't forget about all of the other physical presence requirements described above.
  - The hospital needs to have policies and procedures in place to monitor and assure compliance

Supervision of Hospital Outpatient Diagnostic Services (cont'd)

- Finally, be careful about the supervision requirements stated in your exclusive provider agreement (if you have one).
  - Although no hospitals (to our knowledge) have taken the position that only radiologists are qualified to provide supervision, they might change their position in the future.
  - Also, the physical layout of a particular off-campus hospital outpatient department might prompt the hospital to demand that the radiology group provides the requisite supervision.
  - In any event, your contract probably imposes some type of obligation on the radiology group to assist the hospital with regulatory compliance.

Process

Conversion to Provider-Based or Under Arrangement

Conversion to Provider-Based or Under Arrangement

- Check state hospital licensing requirements to ascertain whether provider-based or under arrangements will work and what compliance steps, if any, will need to be taken (either before or after closing).
- In states with a CON or similar regime, analyze the CON implications.
  - If the joint venture already has a CON, can it be “transferred” or will the hospital only need to obtain a certificate of exemption of similar non-substantive review?
  - Can the center be added to the hospital’s existing CON?
  - Will the hospital be required to obtain a completely new CON and go through a full substantive review?

Conversion to Provider-Based or Under Arrangement (cont'd)

- Do market and related research to ascertain:
  - Reimbursement differentials.
  - Non-governmental payor contracting biases and trends.
  - Can existing hospital payor agreements be accessed? Will they require amendment?
- Analyze a sample billing and collection data set.

Conversion to Provider-Based or Under Arrangement (cont'd)

- Decide whether the conversion makes financial sense and whether the financial justification appears to be sustainable for the mid- to long-term.
  - Remember the transactional costs of getting the conversion done.
  - Also remember the potential reduction in equity value of the joint venture if it becomes an under arrangements contractor, dis-enrolls from Medicare, no longer has its own payor contracts, and changes from having multiple customers to having a single customer (*i.e.*, the hospital).

Conversion to Provider-Based or Under Arrangement (cont'd)

- If seeking provider-based status, fully understand the provider-based requirements and resolve among the participants how they will be satisfied.
- In other words, who will be responsible for what, and where will decision-making discretion sit on issues that are key to provider-based qualification?
- Memorialize the resolution in writing somewhere and have parties sign.

Conversion to Provider-Based or Under Arrangement (cont'd)

- If necessary, modify the joint venture's organic documents, *e.g.*, operating agreement and articles of organization (for a limited liability company).
  - Pay particular attention to buy-out rights and obligations, and related valuation methodologies: do they still make sense?
- Enter into or amend existing service agreements for subcontracted items and services.
- Enter into or amend management and medical director agreements.
  - Remember that for off-campus provider-based status, 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.

Conversion to Provider-Based or Under Arrangement (cont'd)

- Enter into an agreement between the hospital and the joint venture that describes:
  - What will the joint venture do?
  - What responsibilities will stay with the hospital?
  - Where will decision-making discretion sit?
  - How will the joint venture be paid by the hospital?
    - Seek to flow all TC reimbursement to the joint venture, less a reasonable billing and collection fee for hospital and less any expenses attributable to responsibilities retained by hospital.
    - Remember that hospitals are not always paid in a way that is conducive to segregating the TC reimbursement, so expect to build in mechanisms to determine formulaically the TC reimbursement in such circumstances, ideally subject to some type of annual or semi-annual reconciliation.

Conversion to Provider-Based or Under Arrangement (cont'd)

- Modify any existing exclusive provider agreement with the hospital.
- Terminate (or modify) any professional services agreement between the joint venture and the radiology group.
- Be sure to address the new supervision requirements for hospital outpatient diagnostic services: who is going to be responsible?

Process

Sale

Sale

- Hospital should analyze the provider-based requirements and assure itself that it will be able to qualify post-closing.
- At the outset, make sure to analyze the potential tax treatment for the seller and its owners, and structure the deal for tax-efficiency.
- Will likely be transacted as an asset purchase, so prepare an asset purchase agreement.
- Analyze and address any CON and hospital licensure implications.

Sale (cont'd)

- The hospital will likely obtain a valuation, so consider either:
  - Obtaining you own valuation, or . . .
  - At a minimum, retain a valuation expert, familiar with diagnostic imaging, to "scrub" the hospital's valuation as well as to give you a good sense for what is "market" for diagnostic imaging centers.

Sale (cont'd)

- The **KEY** to maximizing the valuation:
  - Persuade the hospital to attribute value to the higher reimbursement it will receive post-closing once the center is provider-based.

Process

Roll-Up

Roll-Up

- Do market and related research.
- Analyze a sample billing and collection data set.
- Expect that the provider-based and/or under arrangement analysis will be even more complex (because inherently there are more centers involved).
- The overall transactional process will also be more complicated if multiple hospitals and multiple radiology groups are involved.

Roll-Up (cont'd)

- The transaction will require documents for the formation of the joint venture:
  - Articles of organization and operating agreement (for a limited liability company, if that's the entity of choice).
  - Asset contribution agreement.
  - Loan and/or other financing-related documents
  - Management agreement(s).
  - Professional services agreement(s) (or modifications to any existing exclusive provider agreement).

Roll-Up (cont'd)

- Valuation will again be perhaps the biggest economic issue to be negotiated (at least from the standpoint of the owners of the supplier-based centers).
- And to reiterate, the **KEY** is to persuade the hospital to attribute value to the higher reimbursement that will be received post-closing once the supplier-based centers are contributed into the joint venture and the services are billed by the hospital.

Process

Common to All

Common to All

- You're probably going to get only one bite at the apple, so take advantage of it.
- If your radiology group needs to find new income sources for the group, these may be easier to obtain as part of a restructuring, sale or roll-up.
  - Coverage agreements.
  - Co-management agreements.
  - Medical director agreements.
  - Recruitment support.

Thank you!

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