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# Hospital–Imaging-center Integration: Complexities in Search of Solutions

BY GEORGE WILEY ON MARCH 12, 2011

*This article is the first in a four-part series on options for integrating imaging centers and hospitals.*


Todd Sorensen, AVA

Given accountable-care organizations, bundled payments, pay for performance, capitation, and medical homes, nobody knows the exact shape that health care will take in the future, but one thing is likely: It won't look like today's fee-for-service model.


Richard W. Townley, MBA


Robert Maier, CPA

Those who operate outpatient imaging centers know this. Many have already seen volumes drop, or have been buffeted by intrusions into their turf. Hospitals, in the future, will be hubs of care, involved in preadmission and post-discharge planning for their chronically ill patients, with an eye to holding down costs. To a degree that they haven't been until now, hospitals will be in the driver's seat. They will have to stay solvent to remain there, however, and this has them looking for new revenue streams.

Reimbursement's vagaries and intrusions into daytime hospital-based imaging by national radiology groups with a heavy emphasis on teleradiology have given radiology groups their own motives to integrate outpatient imaging services with hospitals. Todd J. Sorensen, MBA, an accredited valuation analyst and partner in VMG Health (Dallas, Texas), says that 2010 was a banner year for the integration of hospitals and outpatient imaging centers, and he predicts that 2011 will continue the trend.

Several models for integrating outpatient imaging centers into hospital settings have developed. The most common are outright sales of the centers; joint ventures between radiology groups and hospitals; and lease-based, hybrid arrangements wherein hospitals largely control the imaging center's operations, so as to be able to offer services as provider-based.

## Drivers of Integration

Incentives to transform freestanding imaging centers into hospital-based outpatient imaging providers are market oriented, but diverse. One of the most important (and purely economic) factors is an anomaly that has developed between the rates at which third-party payors, and, to a lesser extent, Medicare pay hospitals and freestanding centers for the technical component of the same procedure. Hospitals are paid more in many cases—and sometimes much more.

Private payors in particular often pay much higher reimbursements to hospitals for outpatient imaging, potentially offering significant advantages for hospitals and for radiology groups that join with them in provider-based imaging structures. "The biggest differential is what commercial payors and managed care are paying hospitals for outpatient imaging," Sorensen says. "It can sometimes even be a multiple of what freestanding centers get for those same services."

Richard W. Townley, MBA, founder, president and CEO of AGI Healthcare Group (San Ramon, California) agrees. "The overwhelming difference is associated with the commercial contract differentials," he says. "We have seen cases where a provider-based commercial payor contract rate for a breast biopsy is up to 10 times the reimbursement a freestanding imaging center receives in the same market, and the rate for an MRI exam may be well over two times greater."

Radiology groups can opt to merge outpatient centers into hospital networks to chase these higher reimbursement levels, but there may be a long-term downside to that strategy. For now, according to Robert Maier, CPA, founder and CEO of Regents Health Resources, Inc, Brentwood, Tennessee, the differential in technical-component reimbursements is falling through the cracks.

Commercial payors are much more focused on inpatient rates in hospital reimbursement negotiations than they on are outpatient imaging technical payments. "There's a real question here how long this differential will last," Maier says. "If we see too many trying to convert freestanding into provider-based imaging, the payors may refuse to pay those higher fees."

Sorensen adds, "There is even the expectation that the differential will go down, and perhaps even go away, because the nature of these structures is more short term." Moreover, Maier says, "Patients' out-of-pocket cost tends to be higher at hospitals, so patients will self-select the lower-cost freestanding center. Hospitals could lose that business by converting a center to provider-based imaging." Despite these risks, the financial incentive, right now, is so attractive that capturing higher technical-component reimbursement is the number-one reason that hospitals and independent imaging centers merge operations.

Townley also cites the risk of volume loss as payors, RBMs and consumers seek lower-cost providers of imaging services. Lastly, he says, many radiology groups are not comfortable with the necessary organizational stipulation associated with restructuring their services to meet the CMS requirements for offering imaging as a provider-based entity.

### Additional Factors

Another driver for both hospitals and radiology groups, in integrating outpatient centers, is plain old security. "Each party is losing a competitor," Sorensen says.

Radiology groups that hold contracts with hospitals for inpatient and emergency-department interpretations, but also operate group-owned freestanding outpatient centers, are targets for merger or takeover by hospitals, and the hospitals have the leverage of granting the inpatient-imaging contracts.

With some teleradiology providers in the market willing to take over hospital contracts, radiologists with existing hospital contracts might be willing to share with hospitals in the ownership and operation of group-owned imaging centers, principally to retain income security via the hospital contract. The radiology groups sell assets to the hospital and share (or give up) technical-component reimbursement in order to retain professional-component reimbursement.

"Radiologists want to secure the professional component, and aligning with hospitals gives them security on the professional component," Sorensen says. Both radiologists and hospitals might look at integration of outpatient centers as opportunities to grow market share. Gaining market share also gives hospitals leverage in contracting with payors, Maier says.

Townley adds, "Hospitals, in the past, were more tolerant of their radiology groups competing with them. They are less tolerant now." That's especially true with teleradiology as an option for some hospitals, he adds: "That model is driving some radiologists to partner with hospitals when, in the past, they would not have been interested."

Another driver of integration is the pressure on both hospitals and radiology groups to position themselves as low-cost imaging providers, especially as new reimbursement models such as service bundling and accountable care emerge. By combining outpatient operations, both participants gain economies of scale, Maier says. Sorensen adds, "Hospitals believe radiologists can operate outpatient centers better than they can."

Maier says, "Everybody's at a tipping point with what could happen here. I don't see radiology groups as happy with the way things are going, with the potential for technical and professional reimbursements being reduced."

**Options for Integration**

When the hospital and radiology group have agreed that integrating outpatient imaging is in the best interests of both, the question then becomes how to do it. Sorensen details the various options that hospitals and radiology groups can employ to integrate outpatient imaging; he calls this the integration spectrum.

At one end of the spectrum, a hospital enters into a joint venture with a radiology group for the group's freestanding center. The joint venture typically covers only the shared technical-component segment of the business, with the professional segment retained by the radiology group.

Another variation is sale of the outpatient imaging center to the hospital outright, with the radiologists capturing only the professional component, Sorensen says. Rarely, hospitals might buy freestanding centers completely and pay the radiologists as salaried employees. In this instance, Sorensen says, the hospital would capture both the technical- and professional-component reimbursements, as the radiologists would provide the interpretations under reassignment.

At the lower end of the spectrum is the CMS-acceptable lease of an outpatient imaging center to a hospital, or a looser arrangement in which the hospital and the radiology group might agree only to exchange purchased services. The deals that hospitals and radiology groups with freestanding centers make will depend on the local market and on both parties' ability to design workable strategies within that market.

"One size does not fit all," Townley says. "If they're restructuring to provider-based imaging, whether it's a joint venture or a purchase, that may be appealing in a smaller market—but in Los Angeles, California, they would hand you your head. The strategy always depends on the local conditions. Radiologists are very concerned about what this will mean to them in the long term; that's why we always include provisions in agreements that they can restructure if the world changes. When we structure technical-component deals, we always have provisions that effectively align the radiology group into long-term reading for the hospital, under acceptable terms."

Maier adds, "The radiologist is looking for long-term security, and both sides are wanting to increase market capture. Most of our radiologists want to maintain an interest in the technical component, if at all possible."

Staying involved can mean different things, however. The radiology group might end up with a 30% to 60% share of the technical component—or no share at all, depending on the local conditions and the negotiating strengths of both sides, according to Maier. Reimbursement sharing can also depend on the value of assets brought to the table. Are radiology groups contributing physical assets and technical infrastructure?

When centers or assets are sold, both sides might not agree on the value of the assets; radiologists within a group might not even agree on the value of the assets and the attendant risks of selling, restructuring or staying the course. "It can depend on how much the radiology group is prepared to put its relationship with the hospital at risk," Townley says. "There may be strong differences of opinion between buyer and seller as to how that transaction should value out, or how compensation should be restructured."

Some powerful radiology groups might only want to share technical-component reimbursement in order to become positioned under the hospital's provider-based umbrella. Weak, threatened groups might be happy to sell centers outright and become salaried employees of the hospital. In the middle might be groups for which leasing is the most viable option. "In terms of what parties want out of this, we're seeing a wide array," Townley says. "There are almost unlimited iterations. The details come into play to help determine the best structure."

Nonetheless, as Townley, Maier, and Sorensen agree, market forces are working in favor of continuing integration of outpatient imaging between hospitals and radiology groups. "There will be overlapping drivers of what each group sees," Maier says. "The key is translating those drivers into a reasonable course of action."

*George Wiley is a contributing writer for ImagingBiz.com.*

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