Financing Outpatient Imaging Initiatives:

The Saint Thomas Health Services Experience

To prepare to meet future health-care–delivery needs, this nonprofit health-care system considered all of the options for financing an ambitious outpatient imaging center initiative

By Tom Blankenship; Jason Dinger; and Sheila Sferrella, MAS, RT(R), CRA, FAHRA

While there have been significant changes in the imaging market over the past 20 years, we continue to witness sea changes within the sector, increasing pressure on operators, administrators, and physicians. Within Saint Thomas Health Services (STHS), Nashville, Tennessee, inpatient and outpatient imaging services are available predominantly in three large system hospitals: Baptist Hospital and Saint Thomas Hospital in Nashville and Middle Tennessee Medical Center (MTMC) in Murfreesboro.

The hospitals' campus-based imaging services are not physically or organizationally distinct for outpatients, but serve both inpatients and outpatients. STHS does, however, have some ownership experience in two freestanding outpatient imaging center joint ventures in the primary market of MTMC.

Freestanding imaging centers (including those owned by competing health systems, physicians, and proprietary companies) are prevalent in the Nashville and Murfreesboro markets. From fiscal year (FY) 2007 to FY 2009, outpatient volumes for MRI and CT at the three large STHS hospitals declined by 19% and 3%, respectively, creating motivation to increase market share. Long-term strategic considerations, including health-care reform, technology, and other factors, also concentrated our attention on outpatient imaging opportunities.

Strategic Context

Beginning in 2009, plans were developed by the STHS strategic-development team led by Wesley O. Littrell, president and CEO of Saint Thomas Affiliates and chief strategy officer for STHS. This series of plans involved STHS and various potential equity partners.

Plan A: As part of a five-year strategic assessment in FY 2009, STHS proposed the development of a network of medical villages that would consolidate outpatient imaging and other ambulatory services near the campus of its Nashville hospitals, with a similar village to be implemented adjacent to its replacement hospital at MTMC (which was under construction). Both projects, with the potential to generate strong returns on investment, were capital intensive; consequently, they were not approved due to competition with other system projects.

Plan B: In late spring 2009, STHS entered into discussions with a corporate partner regarding a joint venture in which the partner would acquire four local imaging centers. In addition, the partner would contribute sufficient cash to develop the original medical-village initiative, and STHS would contribute future hospital outpatient imaging volume for equity in the venture. The two existing, joint-venture imaging centers near MTMC would be contributed and physically consolidated into the village in that market. While this plan was creative and sound in concept, the partner was unable to acquire the local imaging centers and required extraordinary control and management rights in the potential venture, which led to a termination of those negotiations.

Plan C: STHS reached out to both of the radiology groups that provided inpatient coverage to the system's hospitals and to Premier Radiology (Nashville)—a direct competitor operating three large freestanding centers in this market—regarding their interest in discussing a joint-venture network of imaging centers. A four-party confidentiality agreement was signed, and all parties commissioned separate fair-market valuations of their respective imaging enterprises, which would be consolidated in the potential venture. The valuation process involved numerous and frequent meetings between STHS and the radiology groups from September through November 2009.

Part of the challenge, for hospital executives, in funding the growth of outpatient business is that such capital investments are usually made at the expense of the traditional and genuine hospital needs. Plans B and C represented a decision to pursue creative options to fund outpatient imaging growth for the system. A process that started

with identifying three venture-capital companies ultimately yielded the lesson that having the money was only one piece of the equation—a large piece, but not the only one of significance.

Identifying and selecting the right partners were pivotal for this venture. The system reached out to a competitor (Premier Radiology) based on its outstanding reputation for service, its experience in the market, and the success of its existing centers. The cultures of Premier Radiology and MidState Radiology (Murfreesboro)—already an STHS partner—were found to be consistent and based on shared values.

In March 2011, STHS announced the formation of Saint Thomas Outpatient Imaging, a $100 million joint venture of STHS, Premier Radiology, and MidState Radiology that will provide outpatient imaging services to patients at eight locations, making it the largest network of outpatient imaging centers in Middle Tennessee.

Transactional Challenges

It's not surprising that the transaction process, even among these compatible partners, included three significant challenges: valuations, going-forward projections, and definitive-agreement development. It was relatively easy, even with two separate valuation consultants representing different parties, to agree on a valuation approach for existing imaging centers.

In the end, analyses of discounted cash flow (based on consistent methods and assumptions) were used to assign value to the existing imaging centers and to establish the contribution value for the new venture. A similarly consistent approach was taken in determining the value of the contributed future hospital outpatient volumes, based on agreed-upon capital investments necessary to provide service to those volumes under nonhospital revenue and operating-expense assumptions.

Obviously, the parties had a mutual interest in determining how well they would do as partial owners of the venture (compared with the status quo), so the development of a well-vetted common set of operating projections was essential to reaching a shared confidence level and a shared position on the ultimate go/no-go assessment.

There is no good substitute for excellent and knowledgeable counsel; involved early, these individuals can transform a shared vision and operating model into an appropriately constructed vehicle for the venture (in this case, a limited-liability company) and the stacks of corollary contribution agreements, assignments, schedules, and exhibits. Painstaking definition of what one hopes are remote occurrences—such as unwind provisions and agreements for termination of professional services agreements—can be uncomfortable, but it is essential to resolve these questions as early as possible.

Traditionally, nonprofit health-care

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organizations form a conservative group, so the creative financing that led up to the March announcement establishing a joint-venture outpatient imaging company is something of a departure from business as usual. We thank the team that supported us and helped us bring this deal to closure, beginning with Mike Schatzlein, MD, CEO of STHS, who arrived in the middle of negotiations, and our executive sponsor, Wesley O. Littrell, who helped us every step of the way.

We thank our colleagues at Ascension Health (St Louis, Missouri), who assisted us with board approvals and with financing, capital, and legal issues. The team at STHS includes Alan Straus, STHS CFO; Jay Galbreath, director of strategic financial planning; Cindy Williams, director of joint-venture contracting for managed care; and our three acute-care hospitals' CEOs, Bernard Sherry, Dawn Rudolph, and Gordon Ferguson.

Our partners at Premier Radiology include Chad Calendine, MD, president; Michael Moreland, CEO; and Mark Gaw, CFO. Our partners at MidState Radiology include Max Moss, MD; Rick Smith, MD; and Holly Ramsey. We also had tremendous support and guidance from our legal colleagues, E. Berry Holt, Kevin Campbell, and Abbie DeBlasis.

Financing the Imaging Venture

There are three primary vehicles used, alone or in combination, for financing new imaging ventures: debt, private equity, and the joint venture. Both hospitals or physician groups have aggressively pursued unique debt vehicles over the past decade. Low interest rates offered by equipment manufacturers, the desire to retain the majority of equity, and the ability to make independent decisions have made debt an attractive option to many imaging leaders.

Physician practices, however, often have limited cash-flow levels and find it difficult to raise enough debt to continue rapid expansion. Tightening of the credit markets has also made it difficult for centers to gain access to low-cost debt opportunities, further restricting growth and development. Debt financing entails material guarantees, in the form of personal property and assets, to be provided by physicians and other independent owners who want to continue expansion and growth; these guarantees are something that most want to keep to a minimum.

The realities and constraints of debt financing have created a number of new partnerships between large imaging companies and private-equity companies. In this instance, private-equity groups or venture-capital companies provide an influx of cash and resources to accelerate the growth of new and existing centers. In return, most companies take a majority stake in the imaging company, hold most of the governing board seats, and—while perhaps not requiring operating control—can make significant changes in leadership, should performance not meet expectations.

These terms can be very attractive to imaging companies that want to grow aggressively and need a new influx of cash to move into new markets or help fund enough growth to let them become attractive to private buyers or the public market. Many physicians and hospitals, however, have little experience with the private-equity market and are leery of partnering with experienced investment bankers who are solely focused on generating strong returns for their limited partners.

Others have found the forfeiting of control and of the sole ability to dictate a path forward to be the most difficult challenge in working with financing partners. It should also be noted that outside of their financial strength, private-equity and venture-capital companies might provide limited strategic strength in the local and national markets. They might have limited access to new markets, might have few relationships with physicians, and might lack the operational expertise to help with IT integration and other long-term strategic initiatives.

The Joint Venture

For imaging companies looking for a long-term strategic partner that will help with same-store growth and the development of new centers, a joint-venture structure might be the best alternative. In these cases, imaging centers might come together with hospitals or large physician groups. The entities sometimes merge their existing assets into a new company, while in other instances, one entity might provide assets and the other might provide financing.

A joint-venture partner differs from a private-equity company in that it almost always brings a strategic asset and outlook to growing the imaging venture. Some partners might be able to open up new markets where they have hospitals or employed physicians; others will provide financing with better terms, less need for operating control, or unique IT infrastructure to tie the imaging center more closely to its current and potential referral streams.

It should be emphasized that joint ventures come in all shapes and sizes, with equity levels, governance, and operating control varying widely. It is precisely this flexibility that can be the model's greatest strength, allowing partners to craft a unique structure that meets both entities' strategic terms.

It is important to note, however, that the three structures described (debt, private

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equity, and the joint venture) are not mutually exclusive. Many (if not all) joint ventures take on some debt to continue expansion and preserve an adequate cash balance. A private-equity company might also partner with an existing joint venture to help it expand regionally or nationally, increasing its chances of being acquired by a larger player or of eventually entering the public market.

Private-equity companies might also invest in a management company that helps form local joint ventures between hospitals and physicians, taking a minority stake in each venture formed. This has been an especially popular structure, during the past decade, for parties looking for financing and management experience.

Whichever option is chosen, the key is understanding how much you're willing to invest, what level of control you will require, and how large you hope your entity will become. These three fundamental areas not only will dictate which partner will be best over the long run, but will also dictate the areas in which you will most probably need to compromise.

Acquisitions and Alternatives

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Acquisitions can provide immediate cash flow and existing customer and referral bases—key factors if the company is in a highly competitive market and is trying to grow while minimizing risk. Acquisitions, however, are typically more expensive than new centers; therefore, they do not offer the same amount of benefit, in comparison.

This, however, might not be an issue if the partners are looking for relatively low (but stable) returns in a rather competitive or volatile market. Acquisitions can be a great way to gain a foothold in a new market while avoiding the challenge of marketing and developing a new center or brand. It can also be easier to gain financing for acquisitions, as existing centers have assets and cash flows against which lenders can make loans.

New centers are dramatically cheaper than acquisitions, but are much more risky, since there is no existing business (and referral trends are yet to be defined). New centers are, therefore, desired by partners looking for the highest possible returns—and willing to bear commensurate risks.

These risks can be mitigated based on whether existing referrers will support the new center, on whether the company is familiar with the existing market, and on the degree of competition that is currently in place for the new center. Starting from scratch, however, is always riskier than an acquisition—and therefore, financing a new center will be more difficult.

With respect to the question of buying versus leasing, we think it's hard to find a reason to buy real estate. Certainly, if the imaging center is a single tenant, and you can't think of an instance in which you would ever move, buying a building can make financial sense. In nearly every opportunity we've examined, however, it has been much better to lease the building and use cash or other available debt to open or acquire new centers. The return on existing or new centers is much greater than the return on any real-estate investment that we've evaluated.

Financing has also been much easier to identify and secure for growth than it has been for acquisition of an existing building. This is even more likely to be the case with imaging equipment. Given how quickly imaging assets depreciate, using precious cash or financing on an imaging asset is likely to provide much lower returns than investing in expansion or growth in the marketplace could.

Present and Future

Clearly, the financial meltdown and subsequent recession have changed the game for any business that wishes to raise capital. We have found that the current economic environment has produced three primary effects in the health-care marketplace. First, imaging centers must have higher net margins and greater cash balances to qualify for debt financing.

Second, the ability to negotiate better terms depends on the operating history of the company—specifically, on its performance over the past 24 months—giving lenders a baseline for how the organization responds to a down market. Third, if you are working with an asset-based lender, the quality and number of assets can determine how quickly a transaction can take place (and the amounts of any loans that will be made available to the company).

There is no doubt that health-care reform and the escalating cost of health care have resulted in serious debate, within and between health systems, regarding how to position their imaging strategies. Likewise, there is no doubt that the Florida market is behaving very differently than that of

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North Dakota, so there is certainly not a single answer to any question concerning the years ahead. We believe, however, that certain truths do exist.

Hospital outpatient-department rates are unsustainable. These rates, we're certain, will exist for different lengths of time, depending on the market forces in the local community. It is only a matter of time, however, before someone enters the market and competes directly with hospitals—at half the price. Payors might be unwilling, in the short term, to put pressure on their strongest hospitals, but eventually, employers and others will begin narrowing networks to include only the lower-cost providers.

Patient access and prompt physician response are gaining strength in the market. We are seeing more and more hospital-loyal physicians send patients to independent imaging centers. At many (if not all) of these centers, patients can park easily, get their exams done quickly, and be out the door in 45 minutes. The same centers often read studies more quickly, provide more rapid report turnaround, and offer easy access to the image. In these environments, hospitals with strong outpatient-department rates are suffering tremendously from volume declines, rather than pricing pressure—and payors are willing to make concessions on those rates because they are at decreasing risk of paying them.

Given these factors, centers with the lowest costs, highest patient satisfaction, and greatest integration with referring physicians will win in the market, over the long term. Lower costs will drive new volume to these centers, and the experience of patients and physicians will keep them there. RBJ

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STHS Launches Imaging Partnership

Saint Thomas Health Services (STHS), Nashville, Tennessee, announced on March 14, 2011, the formation of Saint Thomas Outpatient Imaging, a new joint venture between the five-hospital system and two of the area's leading radiology groups, Premier Radiology (Nashville) and MidState Radiology (Murfreesboro). Once the transaction of $100 million is complete, Saint Thomas Outpatient Imaging will be the largest network of outpatient imaging centers in Middle Tennessee.

The newly formed imaging provider began offering services on April 1, giving patients access to more than 40 radiologists at eight locations in Nashville and in Cool Springs, Hermitage, Nolensville, Mt Juliet, Smyrna, and Murfreesboro. Several additional sites are under development. Saint Thomas Outpatient Imaging will also serve as the outpatient radiology provider for STHS stand-alone imaging centers, and it will be an integral part of an accountable-care organization. Volume for the venture is projected to exceed 250,000 imaging procedures in its initial year of operation.

Wesley O. Littrell, president and CEO of Saint Thomas Affiliates and chief strategy officer for STHS, considers the transaction to be consistent with the STHS operating philosophy of collaboration and physician alignment. "STHS brings to the partnership a network of five hospitals and other affiliated providers throughout the region, as well as our own outpatient imaging centers," he notes. "Partnering with Premier Radiology and MidState Radiology will result in greater access to lower-cost imaging services and a superior experience for our patients and the physicians we serve."

Premier Radiology, a 30-member radiology group, brings six imaging centers in the Nashville area to the new joint venture. Premier Radiology provides inpatient radiology services at area hospitals in Nashville, at Williamson Medical Center in Franklin, at University Medical Center in Lebanon, and at STHS' Hickman Community Hospital in Centerville. It also offers teleradiology services to more than 90 hospitals and other sites across the United States.

Chad Calendine, MD, president of Premier Radiology, says, "In STHS, we found a joint-venture partner that is as dedicated as we are to building processes and infrastructure that lower health-care costs for our community, and we believe this joint venture will change the face of imaging in the region. We've invested our time and resources in building a model of excellent service delivery that focuses on the needs of our patients and physicians."

Max Moss, MD, medical director and radiologist with MidState Radiology, corroborates Calendine's comments. MidState Radiology is an 11-member group of physicians that is currently a joint-venture partner with STHS in the ownership of two outpatient imaging centers in Rutherford County; both facilities will become a part of the new venture. MidState Radiology is also the sole provider of radiology professional services at Middle Tennessee Medical Center in Murfreesboro, a hospital member of STHS. "MidState Radiology and our practices in Murfreesboro and Smyrna have proudly worked with STHS since 1971," Moss says. "This partnership allows us to streamline our operations and extend our business beyond the communities we currently serve."

—Julie Ritzer Ross

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