To Merge or Not to Merge: The Business and Legal Issues When Radiology Groups Combine with Other Groups

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Disclosure:
NONE

Session Learning Objectives

- Participants today will learn:
  - What many perceive as the business objectives behind mergers.
  - Possible answers to the question of “Whether to combine, and how?”
  - Some of the structural models.
    - Are there alternatives to a full merger?
  - Key legal and regulatory issues.
  - What are threshold/critical questions the groups will need to answer?
  - A framework for a transactional process.

Definitional Assumption

- For purposes of this presentation, the term “merger” is assumed to include both a true merger (in the corporate law sense) as well as asset purchases (that effectively achieve the same business objectives as a full merger).

It’s about control and economics

- Combining tends to be more about the process and about developing creative solutions for addressing control and economics.
- It usually is less about traditional legal and regulatory issues.
- Everyone must address and resolve the control and economic issues up front before getting too far into the process.

And there will be inherent tension

- When groups merge, there is inherent tension:
  - Specialties accustomed to protecting their turf will need to subjugate their personal interests to the goals of the merged group.
  - Each of the constituent groups will have to give up control to the merged group.
  - Each of the constituent groups will have to share economically (at least to some extent).
- Bottom line: what's good for the merged group may not be good for all the specialties, *i.e.*, one or more of the specialties may be adversely affected to a disproportionate degree.

Business objectives for combining or merging in some way

- Position groups better for payor contracting.
- Strengthen physicians of all specialties in their relations across from expanding hospitals and health systems.
  - Remember the potential move under health care reform to combine Medicare Part B payments with Part A payments, and who the likely recipients will be.

Business objectives for combining or merging in some way (cont.)

- Integrate care.
- Create clinical efficiencies.
- Avail the groups of expanded ancillary services opportunities.

Business objectives for combining or merging in some way (cont.)

- Share/reduce costs.
- Improve access to capital for growth projects such as technical component (“TC”) facilities and other ancillary services.
- Share leadership and management expertise.

Business objectives for combining or merging in some way (cont.)

- Position the radiology group better for the long term.
- Pursue new paradigms for operating as radiology providers.

“To combine or not to combine,” and how?

- Do the groups want, and are they ready, to truly “merge” their practices?
- Would the groups prefer to come together in a way that is something less than a full merger?
- If so, how? What are the alternatives?
- What functionalities do they want to share, and what ones do they not want to share?

Structural Alternatives

Full Merger

- A full merger results in a single surviving entity (the merged group) with single tax identification number and single provider number.
- Physician ownership and governance is only in the merged group.
- Physicians become employees of the merged group.

Full Merger (cont.)

- Merged group is the party to and holds all:
  - Payor contracts.
  - From the radiology group's perspective, the merged group holds the exclusive provider agreements with hospitals.

Merger “Lite”

- A new, separate entity is formed with shared physician ownership.
- The existing groups remain intact.
- Certain governance and decision-making rights (such as payor contracting, physician compensation, *etc.*) could stay with the existing groups and certain rights could be transferred to the new entity.
- Certain functionalities could be transferred to the new entity and then shared among the existing groups.

Merger “Lite” (cont.)

- Services for Medicare and other governmental beneficiaries might be billed by the new entity under its own tax identification number (and the new entity would itself enroll with Medicare).
  - HOWEVER, attention would need to be given to the Stark Law issues that may be implicated by a merger of specialty groups that refer (such as cardiac and vascular groups).
  - Also, the relationships among the various groups and the new entity would need to be structured in compliance with Medicare reimbursement rules governing the new entity’s billing for services provided to Medicare beneficiaries.
- Services for non-governmental beneficiaries might be billed by each of the respective existing groups under their existing tax identification numbers and provider numbers.
  - Each of the groups could retain their respective private payor contracts.
  - Any groups that are competitors would need to remain cognizant of antitrust issues.
  - The radiology group could retain all of its exclusive provider agreements with hospitals.

Merger “Lite” (cont.)

- NOTE: because of the Stark Law issues, this model can be difficult to accomplish when radiology groups combine with non-radiology groups such as heart and vascular groups (or, more generally, when groups that refer to each other merge).

MSO

- A new, separate management services organization (“MSO”) entity is formed with shared physician ownership.
- The existing groups remain intact.
- Certain functionalities are transferred to the new entity and then shared among the existing groups.
- All payor contracting is done separately (and the radiology group retains its own exclusive provider agreements with hospitals).
- All services are billed separately by each of the respective existing groups.

Variations on a theme

- There are many variations and hybrids of these alternatives.
  - For example, a so-called “divisional merger” could be pursued, under which a true merger occurs, but professional component (“PC”) compensation and related expenses are segregated by “division,” and each division retains micro-level governance rights and responsibilities.
- Notably, subject to effectively addressing the Stark Law issues implicated by one or more of the groups consisting of specialists who refer, TC facilities and other ancillary services could either be included in the merger or kept separate.

Summary of Key Legal and Regulatory Issues

Antitrust

- Will need to perform a “market power” analysis of relevant product and geographic market.
  - If competitors are not involved, then this should not create an impediment.
- Beware of restraints of trade.
- If the parties to the merger will be exchanging competitively sensitive information:
  - Determine whether such sharing creates antitrust risks.
  - If it may, use a process to assure that competitors don’t get access to such information in a way that would allow them to use it against their competitors.
  - Sharing prices (*i.e.*, fees) can be a real problem.

Payor contracting

- Again, always remain cognizant of the antitrust issues discussed above.
- Consider whether the deal can be structured in a way that would preclude the need for the merged group to obtain new payor contracts.
  - Note, however: because of liability concerns, even in a full merger the groups may opt to use asset purchases to bring the groups together, thereby requiring the “merged” group to obtain new payor contracts.

Payor contracting (cont.)

- THIS IS A CRITICAL THRESHOLD ISSUE.
- If the merged group is going to have to obtain new payor contracts:
  - Will it be able to?
  - What will it cost, *i.e.*, will the payor take the opportunity to extract fee and other concessions?

Stark Law
Prohibited Activity

- “If a physician (or an immediate family member of such physician) has a financial relationship with an entity . . . then the physician may not make a referral to the entity for the furnishing of designated health services (“DHS”) for which payment otherwise may be made” under Medicare (and to some extent Medicaid) UNLESS AN EXCEPTION APPLIES.

Stark Law Exceptions

- In-office ancillary services exception.
- Employment exception.
- Transaction-related exceptions.
- Other available exceptions.

Stark Law Implications

- THIS IS A CRITICAL THRESHOLD ISSUE.

Stark Law Implications (cont.)

- If TC facilities or other ancillary services are economically and clinically important reasons for the merger, then the physicians will need to EITHER:
  - Comply post-merger with the in-office ancillary services exception.
    - They need to think about what this means before they get too far into the process.
    - The merged group will likely need to qualify as a "group practice" which, among other requirements, means it will be limited in how it can pay productivity bonuses and profit shares. . . . OR
  - Structure the transaction so that post-merger, any referring physicians (*e.g.*, cardiac or vascular surgeons) have no direct or indirect ownership in the TC.
    - This by itself can create problems.
    - And it may not be economically acceptable to referring physicians, especially if they benefit financially in ancillary services revenue in their current group.

Stark Law Implications (cont.)

- The merger transaction itself will need to be structured to comply with the transaction-related exceptions.
- Likewise, any financial relationships among the physicians and the merged group which will exist after the merger, but that are not covered by the in-office ancillary services exception, will need to fit within one of the other Stark Law exceptions.

Federal Anti-Kickback Statute Prohibited Activity

- The Federal Anti-Kickback Statute is an intent-based statute which prohibits the offering, paying, soliciting or receiving of any remuneration in return for:
  - business for which payment may be made under a federal health care program or
  - inducing purchases, leases, orders or arranging for any good or service or item paid for by a federal health care program.

Federal Anti-Kickback Statute Prohibited Activity (cont.)

- “Remuneration” includes kickbacks, bribes and rebates, cash or in kind, direct or indirect, covert or overt.
- Only one purpose: the statute has been interpreted to cover any arrangement where only one purpose of the remuneration was to obtain money for the referral of services or to induce referrals.

Federal Anti-Kickback Statute Implications

- The merger transaction itself will need to be structured so that it does not create anti-kickback issues.
  - Everything needs to be done at fair market value, on a commercially reasonable basis, and cannot take into account the volume or value of referrals by or other business generated among the parties.

Federal Anti-Kickback Statute Implications (cont.)

- In a full merger, the physicians should be able to avail themselves of the safe harbor for compensation paid to *bona fide* employees.
- Post-merger, if all of the physicians are employees of the merged group, then this safe harbor should protect them from anti-kickback issues that might otherwise be implicated by the physicians' employment compensation.
- BUT, remember that the Stark Law has limits on how any group practice can pay productivity bonuses and profit shares if the group practice needs to comply with the in-office ancillary services exception.

Differences Between Anti-Kickback Statute and Stark Law

- Violation of the Anti-Kickback Statute is a Federal felony whereas violation of the Stark Law has only civil ramifications.
- The Anti-Kickback Statute requires a *mens rea* (*i.e.*, an “intent” element) whereas the Stark Law is a strict liability law.
- The Stark Law applies to financial relationships between physicians and providers of DHS whereas the reach of the Anti-Kickback Statute is broader.

Differences Between Anti-Kickback Statute and Stark Law (cont'd)

- The Anti-Kickback Statute has “safe harbors”:
  - An arrangement is not necessarily illegal just because you cannot satisfy the elements of a safe harbor.
- The Stark Law has “exceptions”:
  - A physician cannot under any circumstances refer to a provider of designated health services unless the physician’s financial relationship with the provider fits within an exception.

Other legal and regulatory issues

- State analogues to the Federal Anti-Kickback Statute and the Stark Law (including fee split prohibitions).
- Choice of legal entity.
  - This will be particularly important for mergers across state lines.
- Licensure laws for TC facilities and other ancillary services.
- Tax laws related to choice of tax treatment.

Threshold/Critical Questions

ANSWER THESE ASAP!

How much governance will be shared and/or centralized?

- To what extent are the groups/specialties willing to share in governance, and how will governance rights be structured and allocated?
- If there's going to be any amount of integration, then some shared governance and leadership is going to be required.
- Also, the old paradigm of "one physician one vote on all matters" will need to give way to more delegation of governance and decision-making to a smaller board and potentially to an even smaller executive committee ("EC").

What kind of protection will each specialty be given?

- At least initially, and potentially on a quasi-permanent basis, the physicians in each existing group and/or from each specialty will need “protection” (possibly through specified, exclusive rights to select their own representatives at the board, EC and committee levels), at least with respect to certain matters.
  - Generally, such protection should not be permanent: at some point the physicians need to function as a fully-integrated group.

What kind of protection will each specialty be given? (cont.)

- Decisions on specified items with significant potential implications for the physicians such as:
  - Hiring/termination of physicians, at least ones that are from their “previous” group or specialty.
  - Allocation of costs.
  - Capital calls.
  - Mergers with or acquisitions of other groups who have physicians of the same specialty.

What kind of protection will each specialty be given? (cont.)

- Physician compensation/benefits decisions.
  - Will the current compensation methodologies used by the various existing groups/specialties be an impediment to merging or otherwise integrating the groups?
  - Could they be synthesized to a “best practices” approach over time?
  - Physician compensation methodologies could be locked in for an initial period of time, then gradually transitioned to an approach that puts more discretion in the hands of a compensation committee.

What kind of protection will each specialty be given? (cont.)

- Scheduling decisions.
- Payor contracting decisions.

Top leadership roles, and who will initially fill them?

- The leadership roles (and the responsibility within each role) that a “multi-specialty” merged group will require may be different.
- Will there be leadership roles dedicated, temporarily or permanently, for each specialty?
- Are there key physicians who must initially have leadership roles to make the merger work.

Professional component revenue sharing across specialties?

- Will each specialty's PC revenue be segregated and paid solely to it?
- Or will there be sharing of PC revenue across specialties?
- If so, how much of the PC revenue does each specialty want to share, and how do they want to share it?
- At a minimum, are the physicians willing to allocate some of their PC revenue for any shared leadership/management physicians or other persons?

How are ancillary services going to be handled?

- For any group that pre-merger has TC facilities or ancillary services, do they want to include those facilities in the merger or keep them separate?
  - Keeping them separate might be possible, but could be difficult in light of Stark Law considerations.
  - Radiologists may be able to hold separately, but referring physicians probably cannot.
- What about new ancillary services in the future: will the merged group develop them, or will they only be offered to one or more subsets of the physicians?
  - Again, doing everything within the merged group will be more feasible from a Stark Law perspective, but there may be limited ways to develop such services on a specialty-specific basis.

Do the groups want/need a transitional step before full merger?

- If so, components of the merger lite and/or MSO alternatives could be used in transition.
- On the other hand, if the groups start off using a merger lite or MSO, they should decide whether it will be permanent or merely transitory.
- For any transitory components, the existing groups may want to prospectively agree upon a mechanism that either:
  - Facilitates, though doesn't force, potential evolution to a true merger, or
  - Leads automatically to a true merger (perhaps if certain benchmarks are met).

Process

- Before doing anything else, decide whether you even want to get involved in ANY discussions about a merger or other combination.
  - Once discussions start, it can sometimes be difficult to withdraw.
- For radiology groups (depending on what other specialties are involved):
  - It’s important to candidly and honestly self-assess your relative strength and value proposition.
  - Have some ideas on what changes you are willing to accept, and concessions you are willing to make, to deal with the inherent tension when groups of different specialties merge.

Process (cont.)

- Have all groups sign a confidentiality agreement.
- Jointly identify a list of critical threshold questions that should be addressed and resolved as early as possible in the process.
  - These will largely revolve around control and economics.
  - If the proposed merger or combination involves more than a radiology group and one other specialty, *i.e.*, it is a true multi-specialty deal, then consideration should be given to retaining a business consultant as facilitator.
- Always stay cognizant of antitrust issues.

Process (cont.)

- As discussions proceed, prepare a summary of the resolutions to the threshold questions, and obtain approval (albeit only orally) from all the groups.
- On a parallel path, any legal or regulatory issues that may be implicated by the merger should be analyzed, and a preliminary deal structure (with key compliance steps) should be approved (again, orally among the groups).
  - Biggest issue will likely be Stark Law compliance.
  - Another big issue will be reimbursement-related, *e.g.*, payor contracting, Medicare enrollment, *etc.*
- Only then should the parties begin the documentation process.
- Negotiate and close the deal.

Thank you!

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