

Strategies in Healthcare

The Diagnostic Imaging Services Industry – Headed for a Shakeout

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Table of Contents

- 2 Overview of the Deficit Reduction Act of 2005
- 6 Overview of the Diagnostic Imaging Services Industry
- 11 Potential Industry Impact
- 14 Likely Market Response – Where's the Opportunity?

The Diagnostic Imaging Services Industry – Headed for a Shakeout

Frustrated by the inability to contain the explosion of imaging costs over the past decade, Congress abandoned its incremental approach to containing costs and enacted sweeping reimbursement changes through the Deficit Reduction Act of 2005. These changes, which some provider groups are calling “draconian”, will likely result in an unprecedented industry shakeout that will force the exit of some providers and create new opportunities for others to partner, consolidate, or grow services. To make the best strategic decisions about their own imaging services, all providers should understand how this legislation will impact different sectors of the imaging services industry.

Overview of the Deficit Reduction Act of 2005

On February 8, 2006, President Bush signed into law the 2005 Deficit Reduction Act (DRA). This legislation is intended to reduce federal spending by \$39 billion over the next five years, including approximately \$11 billion through Medicare and Medicaid freezes and reductions. One of the more significant portions of the DRA is Section 5102, which will reduce payments for imaging services. The Congressional Budget Office projects imaging savings of \$2.8 billion over five years. However, the American College of Radiology claims that these projections are grossly understated and projects imaging cuts of \$6 billion over the same time period.

The imaging section of the DRA includes two major provisions that will impact non-hospital providers. Both provisions target the technical component of payment for producing the image, rather than the professional component for interpretation.

The main provision will cap technical component payments for imaging services performed by non-hospital providers at rates paid to hospital-based service providers beginning January 1, 2007. The DRA codified another provision that was written into the 2006 Medicare rules that calls for a reduction in technical component payments for certain tests performed on contiguous body parts by 25% in 2006 and an additional 25% in 2007. While the 2006 cuts took place, CMS has opted to postpone the 2007 cuts while it further studies the impact.

Motivations for Legislation

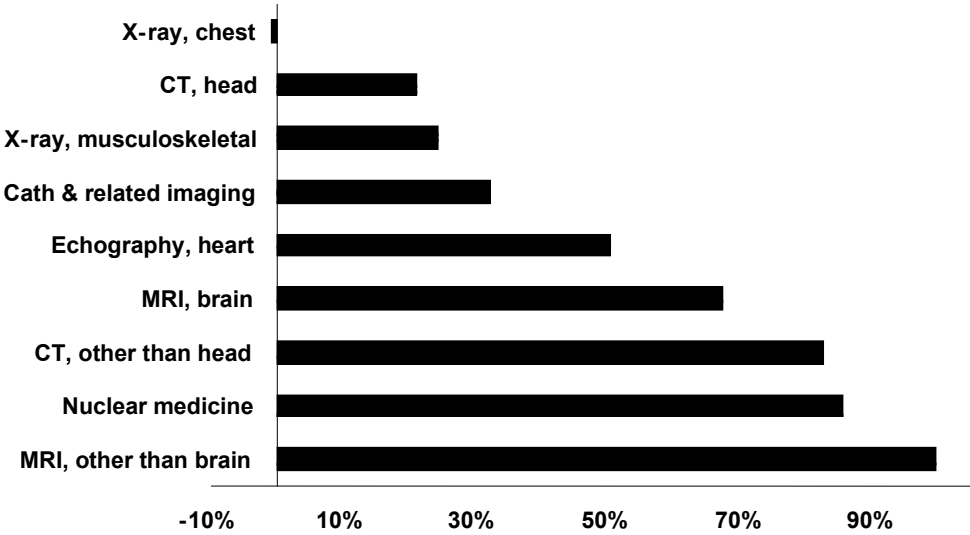
Perceived Over-use of Imaging. The DRA’s imaging provisions were largely influenced by the Medicare Payment Advisory Commission (MedPAC), a federal advisory body commissioned by the Balanced Budget Act of 1997 that advises Congress on issues affecting the Medicare program, which testified to Congress on imaging services in 2005¹. According to MedPAC, diagnostic imaging is the fastest growing component of physician services in the United States, with a growth rate more than twice that of other physician services (45% vs. 22% between

¹ MedPAC Recommendations on Imaging Services, March 17, 2005.

The Diagnostic Imaging Services Industry – Headed for a Shakeout

1999 and 2003). High end modalities including PET, MR, and CT (excluding brain/head) grew by 80%-99% during the same period as shown in Chart A. As an example of rapid growth and overuse of imaging in the U.S., MedPAC cites a *Wall Street Journal* article claiming that there are more MR scanners in the Pittsburgh area alone than in all of Canada.

Chart A: Cumulative Growth in Imaging Volume per Beneficiary (1999-2003)



Source: MedPAC, 2005 Washington G-2 Reports and Shattuck Hammond Partners.

Since the late 1990s, numerous articles reporting dramatic growth and suggesting overuse of outpatient imaging have been published in the general media and medical journals including *The Wall Street Journal*, *The New York Times*, *San Francisco Chronicle*, *Health Affairs*, *The New England Journal of Medicine*, *The Journal of the American Medical Association* and many others. The cumulative body of literature on this subject provided evidence of both professional and public support for a significant change in policy.

Inconsistent Quality. The proliferation of imaging services in physician offices and independent diagnostic testing facilities (IDTFs) has also led to concerns about quality. MedPAC concluded that the institutional standards that govern diagnostic imaging in hospitals are usually absent in physician offices and that IDTFs are generally not subject to periodic survey and certification to enforce quality regulations. The American College of Radiology has gone on the offensive against physician in-office imaging, claiming that outdated or substandard equipment is often used and tests are frequently interpreted by unqualified (i.e., non-radiologist) physicians.

Disparity of Payment Systems. Medicare reimburses for imaging services under two separate payment systems. Hospitals are paid under the Hospital Outpatient Prospective Payment System (HOPPS) schedule and physician offices and IDTFs are paid under the Medicare Physician Fee Schedule (MPFS). Payment rates for individual tests vary considerably between these two systems – with HOPPS higher for some and MPFS higher for others. The DRA

effectively closes the gap between the two systems by capping the technical portion of the MPFS at the HOPPS rate. Since concerns about overuse and quality primarily relate to non-hospital providers, this provision of the DRA targets the non-hospital providers by paying them the lesser of the MPFS or HOPPS, while hospital providers continue to receive HOPPS rates even if they are greater than the corresponding MPFS rates.

The Stark “Loophole.” The Stark Laws generally prohibit physicians from making referrals for “designated health services” with which they have a financial relationship. When Stark II was enacted in 1993, diagnostic imaging centers and radiation therapy centers were included as “designated health services.” However, a specific exception in the Stark laws is the “in-office ancillary services” exception which allows physicians to own, operate, and bill for diagnostic imaging equipment in their offices. Not surprisingly, much of the growth in diagnostic imaging since 1993 has occurred in physician office settings.

The American College of Radiology and the National Coalition for Quality Diagnostic Imaging Services (NCQDIS) have launched massive lobbying efforts to limit the use of in-office imaging services for non-radiologists and have raised awareness of this issue on Capitol Hill. However, rather than imposing additional ownership restrictions or quality controls as these groups had hoped, lawmakers targeted payment cuts through the DRA to reduce the financial incentive for in-office imaging.

Lobbying and Legal Challenges to the DRA

The DRA is being challenged on at least two fronts. Coalitions of equipment manufacturers, physician groups, and IDTF trade groups are lobbying Congress to change provisions of the DRA before payment cuts are fully enacted in 2007. Current lobbying efforts focus on the HOPPS cap provision and argue that it represents drastic payment cuts (30-50 percent) that will result in service closures and significantly reduce access for Medicare recipients. Lobbyists also argue a disproportionate impact on imaging, which represents 10 percent of Medicare payments but absorbs one-third of the total DRA cuts. To mitigate or reverse the payment cuts, Congress would likely need to attach a provision to another Medicare-related bill. While lobbying groups have compiled impressive documentation and are gaining some political support, such a change would be contrary to prevailing political trends towards additional Medicare cuts.

On June 28, 2006, Representative Joseph Pitts [R-PA] introduced a bill, H.R.5704: Access to Medicare Imaging Act, with 42 other bi-partisan co-sponsors to provide for a budget-neutral two-year moratorium on certain Medicare physician payment reductions for imaging services contemplated in the DRA. On July 18th, Congress held hearings to hear testimony from a broad constituency from the imaging industry and MedPAC and CMS. Although it is unclear at the time of this publication the ultimate outcome of this proposed bill, our conversations with a number of industry participants foresee a low likelihood of success of the bill, despite some of the merits of its arguments.

The second level challenge to the DRA is legal. Due to last minute changes in the Senate version, the House and Senate versions were not fully reconciled when President Bush

signed the DRA into law. Members of Congress have introduced a resolution asking for an investigation into the signing of the legislation. Additionally, at least two separate lawsuits have been filed challenging the constitutionality of the DRA. While the ultimate outcome of these challenges is uncertain, it is unlikely that they will be resolved before payment cuts go into effect in 2007.

Overview of the Diagnostic Imaging Services Industry

Delivery Models

Once a hospital-centric service, the diagnostic imaging services industry has been one of the fastest growing, and most rapidly diversifying healthcare sectors. This growth and diversification of providers has spawned an ever-evolving landscape of delivery models. These delivery models have a variety of structural characteristics, which will be affected to varying degrees by the DRA of 2005. These varying characteristics include:

- Provider affiliation:
 - Hospital-based - affiliated / partnered;
 - Radiologist owned or partnered (Stark exception);
 - In referring physician's office (Stark exception); and / or
 - Owned or partnered with a third-party management company.
- Single-modality vs. multi-modality facilities;
- Mobile vs. fixed site providers;
- Wholesale billing (bill provider – hospital or physician) vs. retail billing (contract with payers directly);
- High-tech providers (PET, MR, CT) vs. low-tech providers (X-ray, Ultrasound, Nuclear Medicine); and
- Niche specialty offerings (i.e., Breast MR, Heart Scans, etc).

Industry Participants

Presented in Table 1 is a breakdown of the current industry participants. In general, over the past 20 years, the sector has seen highly cyclical financial performance, with far more downside than upside. This has driven substantial consolidation over the last ten years, generally with mixed results. Consolidation in the mobile space has proven highly effective in stabilizing the market, while consolidation in the fixed site sector has been hit or miss, with numerous strong imaging franchises being destroyed by poor management and flawed integration (i.e. US Diagnostics Labs, Inc.). The only consistent exception over that time period have been focused, regional providers who have developed a strong network of facilities and the ability to exert significant market muscle and high-customer service to produce consistently superior financial returns.

Table 1: Diagnostic Imaging Participants

<i>Delivery Model</i>	<i>Representative Companies</i>	<i>Modalities Covered</i>	<i>Billing Status – Retail or Wholesale</i>
<i>Management Companies – Imaging Centers</i>			
National Focus	<ul style="list-style-type: none"> • Alliance Imaging • CDI – Onex • HealthSouth • InSight Health Services • Medical Resources • MedQuest • Radiologix 	MR Only, PET/CT Only and Multi-Modality	Retail
Regional Focus	<ul style="list-style-type: none"> • American Radiology • DIC – Kansas City • Primedex - California • River Oaks - Houston • Services – Maryland • University MR – Steinberg – Boca Raton 	MR Only and Multi-Modality	Retail
Niche – Open MR, Upright MR	<ul style="list-style-type: none"> • Horizon Diagnostic Centers • Nydic • Soteria 		Retail
<i>Management Companies – Mobile Providers</i>			
National/Regional Focus – High-Tech	<ul style="list-style-type: none"> • Alliance Imaging • DMS – OtterTail • InSight Health Service • King’s 	MR, PET and CT	Wholesale – Hospital Clients
National Focus – Low-Tech	<ul style="list-style-type: none"> • DMS • Mobilex • Navix • Shared Medical Tech 	X-Ray, U/S, Nuclear Medicine	Wholesale and Retail, Hospital, Physician Offices, LTC Facilities and Prisons
<i>Physician Offices – High Tech</i>			
In-Office – Cardiac		CT	Retail
In-Office – Oncology		CT, PET	Retail
In-Office – Ortho		CT, MR	Retail
In-Office – Multi-Specialty		All	Retail

The Diagnostic Imaging Services Industry – Headed for a Shakeout

<i>Delivery Model</i>	<i>Representative Companies</i>	<i>Modalities Covered</i>	<i>Billing Status – Retail or Wholesale</i>
<i>Physician Offices – Low Tech</i>			
In-Office – Women's		Mammography Ultrasound	Retail
In-Office – Cardiac		Ultrasound, NM	Retail
In-Office – Multi-Specialty		All	Retail
<i>Hospital Based Imaging</i>			
Hospital-Based (HOPPS)		All	Retail
Hospital - Affiliated Outpatient Facilities (MPFS)		All	Retail
<i>Single Site Operators</i>			
Radiologist Owned		All	Retail
Entrepreneur – Non-HC Owner/ Operator		All	Retail

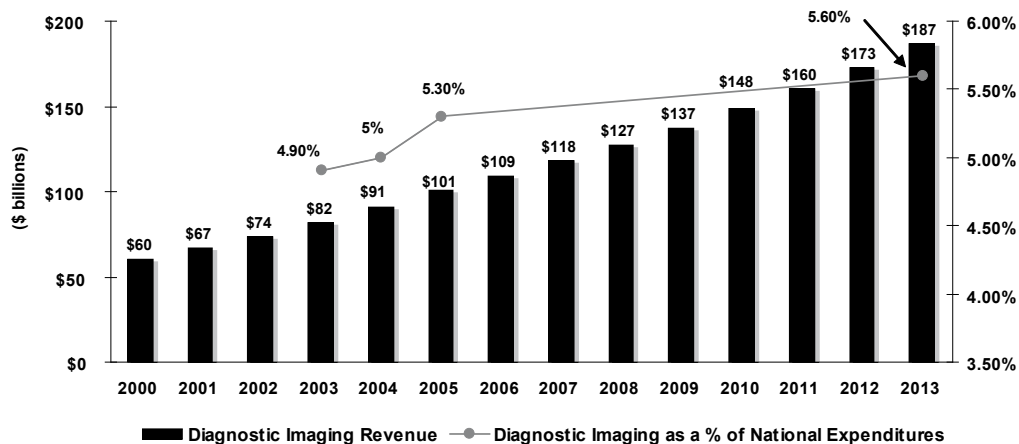
Utilization Trends

Diagnostic imaging utilization has experienced double-digit growth, year-over-year, for the past two decades, and this growth has been driven by several factors that show no signs of slowing:

- Demographic trends (i.e., aging population);
- Extraordinary application growth;
- Pressures of defensive medicine;
- New technologies;
- Improved patient access and consumer awareness;
- Reduced barriers to technology access:
 - Reduced new equipment costs / focused (de-featured) specialty offerings
 - Used equipment availability
 - Creative financing offerings and mobile services access; and
 - Increased marketing by service providers.

Chart B illustrates the corresponding growth in imaging revenues and the projected continuation of this trend before the enactment of the DRA.

Chart B: Diagnostic Imaging Revenues and Percent of National Expenditures



Note: Data for years 2000 to 2005 is actual; data for years 2006 to 2013 is forecasted.

Source: MedPAC, 2005 Washington G-2 Reports and Shattuck Hammond Partners.

Many states have attempted to slow the pace of expensive technology proliferation through certificate of need (CON) legislation. In 2005, 23 states had CON restrictions on imaging modalities². Yet, in all but a few states, these restrictions have not had a significant impact on the pace of imaging technology acquisition, as many providers have utilized alternative delivery models or creative financing vehicles to circumvent CON requirements.

Over the past 20 years, reimbursement rates have generally trended downward for high-tech procedures. In the early 1990's, significant overcapacity of MRs in the market, especially in California, and early market pressures of managed care caused declines in reimbursement (down 30%+) that are comparable to those scheduled in the current DRA 2005 legislation. Several years of financial disarray plagued the imaging services market, and it took the combination of several forces before the sector regained solid footing in the mid-late 1990's, including:

- Consistent 10-20% year-over-year volume growth;
- Introduction of MR angiography and other highly reimbursed MR studies;
- 20-30% reduction in the cost of MR equipment by the original equipment manufacturers (OEMs); and
- Creative debt restructuring of distressed providers by the OEMs whose lending arms were creditors to the majority of the free-standing market.

² The CON Matrix of 2005 Relative Scope and Review Thresholds: CON Regulated Services by State, compiled by Thomas R. Piper Missouri CON program, January 19, 2005.

Payer Response

Not unexpectedly, payors have utilized numerous efforts to curtail and control utilization growth, each with some impact on access, but these efforts have been consistently outpaced by application growth and broader specialty utilization. From early pre-authorization efforts to Highmark's (PA Blue Cross) multi-modality requirements³ to recent contiguous body part legislation, the payers have been struggling for years to slow the staggering pace of imaging expenditures within their plans.

Regulatory Response

Numerous regulatory initiatives have been introduced to try to control access and utilization. As discussed earlier, regulatory initiatives, like the Stark Laws, focused on self-referral controls. Recent efforts to control access and ensure quality have focused on “care standards” (e.g., radiologist on-site, facility accreditation requirements, etc.).

³ Five modality minimum required in an IDTF to be a credentialed provider.

Potential Industry Impact

Facilities Impacted

The DRA imaging provisions directly impact any facility that is reimbursed under the Medicare Physician Fee Schedule (MPFS). This includes physician offices/group practices and freestanding imaging centers (IDTFs) operated by single site operators or national/regional management companies. As shown in Table 2, the only provider group not negatively affected by this legislation is hospital-based providers. The level of potential impact is portrayed on a 1-10 scale, with 10 being the most negative.

Table 2: DRA Potential Impact on Industry Participants

<i>Delivery Model</i>	<i>DRA 2005 Impact (1-10)</i>
<i>Management Companies – Imaging Centers</i>	
National Focus	• Significant – (8)
Regional Focus	• Significant – (7)
Niche – Open MR, Upright MR, etc.	• Significant – (9)
<i>Management Companies – Mobile Providers</i>	
National/Regional Focus – High-Tech	• Near-term: Minimal (2) • Long-term: Increasing (5)
National Focus – Low-Tech	• Varying by modality concentration and client type
<i>Physician Offices – High Tech</i>	
In-Office – Cardiac, Oncology, Ortho	• Significant (8)
In-Office – Multi-Specialty	• Moderate to significant (7)
<i>Hospital Based Imaging</i>	
Hospital-Based (HOPPS)	• Near-term: Favorable
Hospital –Affiliated Outpatient Facilities (MPFS)	• Near-term: Significant (7) • Long-term: Moderate - Favorable
<i>Single Site Operators</i>	
Radiologist Owned	• Significant (7)
Entrepreneur – Non-HC Owner/Operator	• Significant – Catastrophic (10+)

Publicly-traded imaging companies took a beating almost immediately after the DRA was enacted – and nearly a year before the full payment cuts take place. **Radiologix (ASC: RGX)**, a leading national provider of diagnostic imaging services with 72 imaging centers in 7 states, lost 51 percent of its market value by February 9, the day after the DRA was signed into law. In April 2006, Standard & Poor’s lowered its credit ratings on three diagnostic imaging companies citing the impact of the DRA. **The Center for Diagnostic Imaging** and **MedQuest** were downgraded as well as **Radiologix**, which received a double downgrade and a negative outlook.

Radiologix and **Primedex Health Systems (OTCBB: PMDX)** announced plans to merge in July 2006. This transaction is scheduled to close on November 15th.

While the large national and regional companies will suffer, it is the single-site operators who will be the most endangered in what will probably be the most significant shakeout in the history of the imaging industry to-date. Many of these providers are heavily leveraged and lack the diversification necessary to offset the revenue cuts. With fewer resources available to update and replace equipment, these providers will become less competitive as consumers increasingly differentiate based on perceived quality and value.

Similarly, physician offices and groups will lose much of the economic incentive to operate or reinvest in their own high-end in-office imaging, particularly MR and CT.

Impact on the Equipment Market

The most important indirect impact of the imaging provisions in the DRA will be the change in the demand and supply of imaging equipment. The pace of sales to physician offices, multi-specialty groups and imaging center management companies will slow dramatically over the next several years. Additionally, a significant number of providers will choose or be forced to discontinue imaging services, thereby putting used equipment on the market. The resulting surplus of used equipment will place downward pressure on equipment prices and dampen demand for new equipment. Indirectly, mobile service providers will be impacted as smaller hospitals are able to buy used equipment or access lower priced new equipment from aggressive OEMs responding to the reduced equipment demand, rather than contract for mobile services.

Services Impacted

High-end imaging (i.e., CT, MR, PET) is the primary target for cost reduction and will be the hardest hit. It is no coincidence that these services have also historically been the fastest growing and most profitable for providers.

The contiguous body part provision of the DRA only applies to certain CT, MR, and ultrasound procedures. The controversial practice of “full body scans” is directly under attack here. General x-ray/fluoroscopy, mammography, and bone density scans are not included in this provision, and therefore will not be negatively affected.

According to analysis conducted by the American College of Radiology, the HOPPS payment cap provision will affect PET, MR and CT/MR angiography procedures the most.

Table 3: Estimated Impact of HOPPS Cap on Technical Fees

<i>Common CPT</i>	<i>Description</i>	<i>Reduction</i>
70548	MR Head Angio W/WO Contrast	42%
70551	MR Head WO	22%
70553	MR Head W/WO	49%
70496	CT Head Angio	30%
71250	CT Thorax WO	20%
72131	CT Lumbar Spine WO	20%

Note: Some PET and Ultrasound studies are impacted by over 40%, and the proposed PET HOPPS reductions will drive the impact on certain procedures to over 50%.

Commercial Payer Response

Commercial payers have also grown extremely concerned about the rapid growth in imaging costs. Even prior to the announcement of the DRA, commercial payers had begun to limit payments on diagnostic imaging services using standard industry practices such as provider profiling, preauthorization, and limited privileging. Historically, commercial payers have followed Medicare’s lead in cost reduction initiatives, and it is reasonable to assume that they will do so for imaging as well, thus exacerbating the impact of the DRA.

Recognizing imaging as a cost target for commercial payers, the leading behavioral health benefits manager, **Magellan Health Services, Inc. (NASDAQ: MGLN)**, recently chose to expand into the radiology benefits market by acquiring **National Imaging Associates**, the leading benefits manager for radiology services. In assessing its opportunities, Magellan recognized that most of the fat has already been trimmed from behavioral health, but significant opportunities exist for helping commercial payers cut costs in diagnostic imaging.

Likely Market Response – Where's the Opportunity?

Original Equipment Manufacturers (OEMs)

While not a provider itself, this group's response to the DRA will greatly impact providers. The OEMs will likely accelerate their trend towards offering lower-cost, specialized, de-featured equipment in an attempt to preserve some channel to physician offices. At the same time, they will likely shift their sales focus towards the hospital sector, which will be the long-term beneficiary of the DRA cuts. As a result of the anticipated precipitous decline in sales to the outpatient market, the OEMs will likely be more aggressive than in the past in offering deals to hospitals to fill the outpatient void.

In the early 1990's when imaging reimbursement took a comparable free-fall, the OEM's financing arms were in dire credit positions as a result of aggressively financing many of the most adversely affected market players. At that time, the OEMs collaboratively "worked-out" their outstanding finance obligations, while the owners waited a couple years for volume growth to save their franchises. Today, with margins on equipment and service much tighter, credit standards more challenging, and the recognition that their primary customer, the hospitals, will be unaffected and the subsequent beneficiary of the legislation, the OEMs are much less likely to bail out the outpatient sector.

National and Regional Imaging Center Management Companies

The large national and regional management companies will be severely impacted by the DRA cuts. In markets where they have strong networks of facilities and possess some market strength, they will also focus significant effort on curtailing the commercial payers' efforts to follow Medicare's lead. The national players will actively seek to exit or further partner in markets where they do not possess adequate market leverage. Additionally, similar to the early 1990's, companies within the sector will likely pursue significant cost cutting and layoffs to help them weather the storm as they once again wait for volume growth over the next several years to return them to viability. Efforts to restructure their debt and obtain additional needed capital will be much more difficult and costly, as most of their debt is held by third-party bondholders versus the much more flexible financing arms of the OEMs.

Mobile Providers

In the near-term, the mobile players, whose primary customer base is hospitals, will see little impact and may even see some increased volume as some of the outpatient market contracts. However, over time, as their existing contracts with hospital clients expire (typically 3-5 year terms), the OEMs can be expected to pressure hospitals to go in-house. CONs will help protect some of their client base, but increased availability of used equipment will increase access to "approved" equipment in many CON states.

Mobile providers may seek to “partner” with physician practices which may own imaging equipment that, on a full-time basis, is no longer economically viable. Mobile providers, whose primary value propositions are logistics management and asset management, could use those resources to redeploy the physician’s assets and coordinate an economically viable route amongst a group of practices and their hospital clients.

Physician Offices

As indicated previously, DRA cuts will have a dramatic impact on physician offices that own imaging equipment; however, unlike focused imaging center operators, they have broader financial resources and a more diverse revenue streams to help them weather the storm. They also have a “self-contained throttle” on volume and have historically responded to reimbursement cuts by increasing access and driving volume. Many physician offices may pressure their local hospitals to acquire or partner in order to better utilize their excess imaging capacity or may look to other third-party partners, such as mobile providers.

Single Site Operators

Single site operators will generally be the most severely affected by the DRA cuts. Radiologists will likely pressure their local hospitals to partner with them or acquire their facilities. Facilities owned by non-healthcare entrepreneurs will likely find deaf ears in their efforts to find a party to bail them out, as most of the other market participants would prefer to see some contraction in access.

Hospitals

For hospital systems the economic impact on hospital systems and resultant range of market opportunities will vary significantly, depending upon how they currently access and offer diagnostic imaging services and the nature of their competitive and regulatory landscape. In general, hospitals should actively review their strategic options to maximize opportunities resulting from the outpatient dislocations produced by DRA. Additionally, they need to be prepared to respond to - and balance the impact of - numerous market participants (i.e., OEMs, physician practices, radiologists, management companies, etc.) who will look to them as a “White Knight”. The DRA should provide ample opportunity for those health systems with a clear and informed imaging strategy to recapture some of the imaging revenue they have been losing over the past two decades.

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