

Optimism and Innovation in Health Care Battered by Reality

By: Robert Cloutier—October 2013

I graduated from high school in 1995 and left for the military a few months later. I wasn't sure of what I wanted to do but I was advised to make sure I was trained for a civilian-sector job. In other words, I was not to follow my brother's path and drive tanks because the demand for such specialists outside of the armed forces is zero. So, I chose to become a medic and an x-ray technologist figuring that was a safe bet.

After my military commitment was fulfilled, my plan worked out and I was hired for a private x-ray company. Years later, I was cross-trained in magnetic resonance imaging (MRI) and bone densitometry. Approximately a decade later, and after working in various positions within radiology, I decided that I wanted to do more and I starting taking classes in the evening. After several years in school, I graduated from business school where I earned an MBA from Arizona State University (ASU). At that time (2006), ASU boasted the very best supply-chain MBA program in the Nation. Intel, Honeywell and Boeing employees made up the majority of the student body and I was the lone radiology person in the program. On the first day of classes we had to introduce ourselves to our peers and when it was my turn, I received a few interesting looks from the faculty. Many of them were perplexed as to why a non-engineer, working in diagnostic medical imaging, might want to learn about how to move aircraft engines around a factory (my attempt to trivialize ASU's supply chain education). I explained that it was my mission to lean out the process of acquiring healthcare services—specifically, make it easier to get an MRI.

While taking those business classes, I was part of three radiology start-up businesses and was busy designing a fourth. In addition, I was flying to Houston, San Francisco, Los Angeles and Las Vegas to give weekend lectures on MRI physics, scan protocols and equipment features. General Electric and Siemens' executives were contacting me asking for my input on scanning protocols and requesting that I fly to their customer's sites to teach MRI physics. Back in Phoenix, I teamed with the local radiography school and was cross-training their top graduates in MRI. In 2009, I was offered the position of MRI Program Director at the West Coast Ultrasound Institute and I accepted—I had quickly become a leader in the MRI arena.

Through the aforementioned start-up businesses, I met Len Spooner, CEO of a company called Magnaserv. Len is an expert in the procurement, maintenance and leasing of used MRI equipment. After spending a few years with Len, my understanding of the MRI field extended to the hardware side of the business—I now knew the “back-end” of the business. I then understood what equipment is sufficient for specific exams, the associated costs and was learning how to “trim the fat” in an industry with high fixed-costs.

In 2010, I had a simple idea—to help patients get an affordable and high-quality MRI in a timely fashion. I was bothered by the money that patients had to spend, the lack of

quality control in the industry and the rigmarole process which is the third-party insurance game of authorizations, denials and waiting. I mentioned my idea to a mentor of mine and she recommended that I reach out to another MRI expert in Ontario, California. After getting in touch with the engineering group in California and explaining my idea, the CEO decided to fund a pilot so I could prove the concept. With that meeting, Radiology Provider Network (RPN) was born and in May of 2010, we opened in San Diego and offered \$295.00 MRI exams (approximately 40% lower than our competitors). Our first center made a few, small headlines:

<http://clearhealthcosts.com/blog/2012/02/rpn-of-california-home-of-the-295-mri/>

<http://www.healthnewsreview.org/2012/11/how-much-does-an-mri-cost-295-or-3000-both/>

- How is this price point possible?
- Is the quality comparable to the hospitals that are charging \$2500.00?

These were the questions I was fielding on a regular basis. The answer to question one is yes, but the explanation is a multi-faceted one as it came from my many years and experiences in the field. In short, here is the answer: RPN was utilizing refurbished General Electric, 1.5 Tesla MRI scanners (considered the gold standard in the industry) and we were placing them in mobile units. My partner could procure one of these units for roughly \$225,000 and after about \$60,000 worth of refurbishment, upgrades and service; the units were ready to be put in the field. San Diego unit pictured below:

RPN's protocols were efficient and each exam took about twenty minutes to complete. In a standard eight-hour day, RPN could complete approximately fourteen exams. With a profit margin of about \$100.00 per exam, monthly net profit would yield approximately \$30,000.

However, RPN never realized those scan totals due to the several layers of inefficiencies in place, which make physicians and intermediaries extremely wealthy. As far as the quality—top notch, to include both the technical competency and the customer care.



- Why did RPN not see more patients?
- Aren't there several laws in place to make sure private doctors and intermediaries cannot make money on ancillary services such as ordered MRI exams?

RPN tried a direct to consumer marketing campaign but it turned out to be very costly. When it worked, patients informed their physicians that RPN's costs were lower, but those clinicians still steered them towards MRI centers where the doctors had a financial incentive—often times citing quality and trust level with the MRI provider as the reason why they should not utilize RPN. RPN then focused on the industrial side of medicine trying to lower costs for injured workers but in that arena there are several third-party administrators of health services, that again, played the role of “gatekeeper” and “skimmer.” In this model, the intermediary would arrange services for the injured worker on behalf of the employer, but would utilize their own network of imaging centers (costs were higher but the intermediary received a kickback from using certain MRI facilities, often times without disclosing that to their clients).

But what about anti-kickback statute and the federal Medicare Stark Law? Aren't these in place to disallow these types of arrangements? Yes, well, sort of—but with any governance, loopholes develop rapidly. The Stark Law allows for the in-house exemption, which permits doctors to profit from the ordering of MRI exams as long as the machine resides under the same roof. So, doctors pool their resources, share a building and buy a machine. The math is easy to understand as MRI costs are mostly fixed, so at a certain point it is simply a numbers game. If the doctors order over 200 or so monthly MRIs, they can make money. Another arrangement sees doctors buying the equipment or real estate for which MRI centers utilize and then the physicians lease the capital back to the MRI providers, earning a fixed return at fair market value. In either arrangement, the goal is for doctors to order as many MRI exams as possible. When this happens, the patient's best interests, specifically regarding price point and quality, are lessened or in many cases, ignored all together.

After enduring these challenges for over two years and not being able to reach the consumer, I decided to float a proposal to Costco. After all, Costco's mission is to bring high quality and affordable consumables to the public. In recent years, Costco has offered certain health care services so I gave it a shot. The vision was to equip each store with a permanent MRI unit in the back of the building and offer high-quality, \$249.00 MRI exams to anyone needing an exam. MRI utilizes non-ionizing radiation (the non-harmful type) and it is extremely informative in the diagnosing of many musculoskeletal and neurological disorders. Many patients cannot get these exams done primarily due to the cost and the arduous process—Costco could have changed all of that. I put together a thoughtful proposal and never heard back.

Several months later we were able to expand into Arizona as I reached an agreement with a Medicaid payer. They were excited about the cost savings and were “on board,” until we opened and then they did not send us any cases. I reached out to them several times and I was told that if they steer MRI cases to RPN, they would risk angering local

physicians that wanted the freedom to send their cases where they wanted (in other words, where they had a financial interest). Soon after that, the Arizona offices closed, as once again, we could not reach the consumer directly. These issues are well known and there are several agencies that are trying to bring transparency to health care. The V-BID Center at the University of Michigan, Cast Light Health and champions such as Bill Rusterberg from the Cost-Plus Network in Texas are fighting to lean the system out. However, it is difficult to accomplish this needed change because physicians and health plans are still in control. As long as the system allows for intermediaries to stand between buyers and sellers, there will be inefficiencies.

RPN was a thoughtful model utilizing refurbished, high-quality equipment, leveraging industry expertise and challenging the status quo to make a difference in the health care market. We were too small, too optimistic and not nearly tied-in enough with the decision makers to move the concept forward. The lessons are numerous and for me, I know we used our expertise and experience for good. Further, from my travels I met other health care experts trying to do the same—leveraging expertise and experience for positive change. As we sit optimistically on the leading edge of the Affordable Care Act, let us remember, that as long as we allow intermediaries to exist and do not govern who actually benefits from the ordering of health care services, we are fighting an unwinnable battle.

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