Maximizing Practice Independence – Options for Aligning with Hospitals in the Era of Health Care Reform

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Trends in Hospital-Physician Collaboration

- Employment
- Practice acquisitions
- Community oncologists move on-campus or into hospital-affiliated groups
- Integration and alignment for to improve quality and efficiency and for multi-disciplinary care
- Legal developments as a constraint

Oncology Practice Acquisitions

- Valuation challenges/issues—commercially reasonable, FMV, and can't vary with anticipated referrals
  - Payment for goodwill, non-competes
  - Tension between on-going business value and anticipated referrals from selling physicians
  - Stark law and sale of ancillaries
  - Trade-off of compensation/price
  - No earn-out if sellers in position to refer
- Tax structuring to maximize net payment

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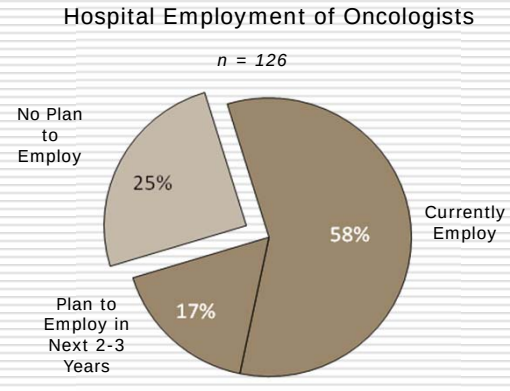
Hospital Employment of Oncologists



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Physician Employment

- Increase in employment by hospitals
- Projected shortage of oncologists
- Change in attitude of younger physicians toward employment
- Financial distress of community medical oncologists
- Desire to integrate, align and control destiny
- Less legal risk
  - Joint pricing without violating antitrust
  - Refer and share ancillaries without violating fraud and abuse laws
  - Hire for competitive purposes, not just community benefit

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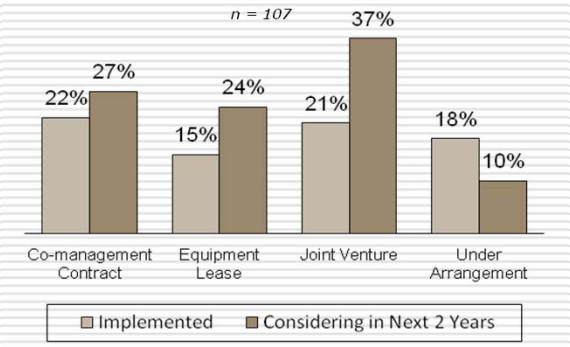
Hospital Interest in Collaborative Arrangements

Percentage of Hospitals Having Implemented or Considering Alignment Models[1]



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Professional Services and Co-Management Arrangements

PSAs: Introduction

- Professional Services Agreements
  - Powerful tool
    - To staff existing Hospital cancer center or develop new hospital facility
    - To convert existing group sites to Hospital licensed facilities paid at hospital outpatient payment rates
    - To integrate and align Hospital and Group to improve quality, efficiency and operations of Hospital's oncology service line

PSAs: Introduction

- Potential economic win-win
- Group paid fair market value compensation on an aggregate fixed fee or wRVU basis
  - Eliminates risk of reimbursement reductions and collection risk (free care/bad debt)
  - Other opportunities: purchase of equipment, management services, employee lease?
- Hospital establishes new satellite site(s) or facility(ies) and new book of oncology business
  - Good contribution margin due to combination of hospital rates and physician office cost structure
  - Potential 340B pricing opportunity
- Potential economic losers
  - Payors—higher rates for "same" services
  - Higher patient co-pays

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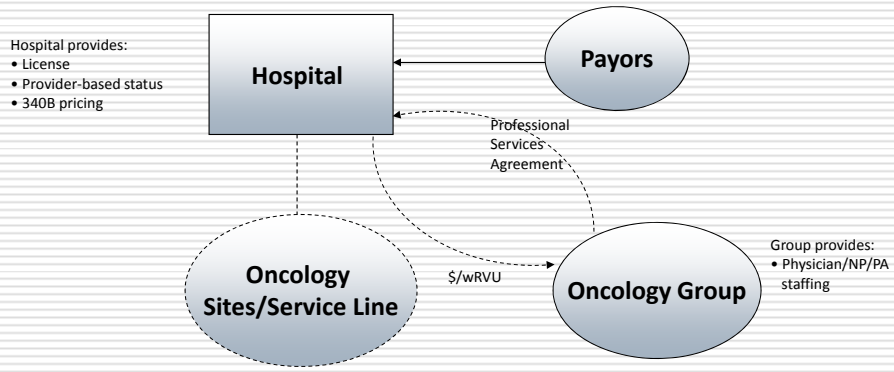
Professional Services Agreement-Basic



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PSA Transaction

- Avoid U/A transaction—Group cannot have investment in entity that "performs the service"
  - Hospital can take assignment of Group leases from landlords
  - Hospital can purchase Group's FFE and inventory at fair market value
  - Hospital must employ nurses/techs at off-campus locations (to meet Medicare provider-based status rules)
- Group can provide all other staff
  - Physicians/NPs/PAs
  - Non-clinical staff at all sites
  - Nurses and techs at on-campus sites

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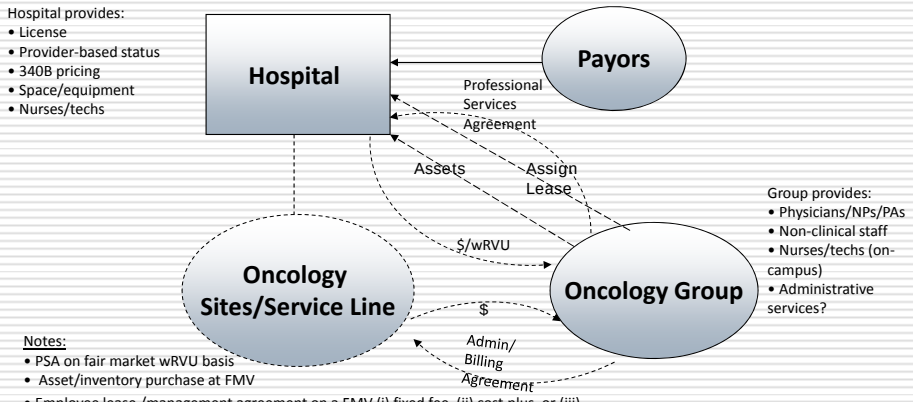
Professional Services Agreement



Notes:
- PSA on fair market wRVU basis
- Asset/inventory purchase at FMV
- Employee lease /management agreement on a FMV (i) fixed fee, (ii) cost plus, or (iii) percentage of collections or NOI with a FMV floor and cap
- Billing services at fair market percentage of collections or fixed fee per claim?

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Principal PSA Legal Issues

- Stark Law
  - Under arrangements prohibition: cannot have investment interest in entity (including own medical group) that "performs" the DHS service
  - "Stand in the shoes"
  - Must satisfy personal services, fair market value or indirect comp exception: fair market value requirement--independent appraisal advisable

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Principal PSA Legal Issues

- Anti-Kickback Statute
  - Approximate personal services and management contracts and/or space or equipment rental safe harbor
    - fair market value/independent appraisal again strongly advised
  - Some irreducible AKS risk: aggregate compensation not set in advance if wRVU based personal services; management contracts and/or space or equipment rental safe harbor may apply to accompanying arrangements

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Principal PSA Legal Issues

- Tax Exemption Considerations
  - No inurement/private benefit
  - No excess benefit transaction
    - Rebuttable presumption of reasonable compensation process
  - Rev. Proc. 97-13 and private use of bond financed space or equipment/duration limitations (3 years/2 year out)

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Principal PSA Legal Issues

- Provider Based Status Regulations
  - Within 35 miles of main hospital campus
  - Hospital license requirement/physical space, life safety standards
  - CON may be required
  - Clinically, financially and administratively integrated
  - Standard hospital reporting lines
  - Hospital must directly employ mid-levels/techs at off-campus sites (other than NPs/PAs)
  - Oncology group can lease non-clinical staff and NPs/PAs to Hospital
  - No off-campus joint venture if provider-based status desired

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Other Key PSA Issues

- Payor pushback
- Role in governance of service line
- wRVU valuation issues
  - Relation to existing physician compensation/ margins on drugs, imaging, labs, etc.
  - Benefits/other continuing expenses
  - New physicians/NPs/PAs
  - Anti-dilution protection
  - Harmonizing with alternative, changing payment arrangements
- No overlap of duties/double payment
- Timing of 340B eligibility/cost report

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Other Key PSA Issues

- USP 797 standards and state pharmacy rules
- Staffing Issues
  - Mixed hospital/group staff (off-campus) and salary/benefit differentials
  - Union issues
- Unwind rights
  - Asset repurchase
  - Lease assignment/real estate repurchase
  - Solicitation of employees
  - Data/records access/transfer
  - Systems issues
  - Non-compete exception

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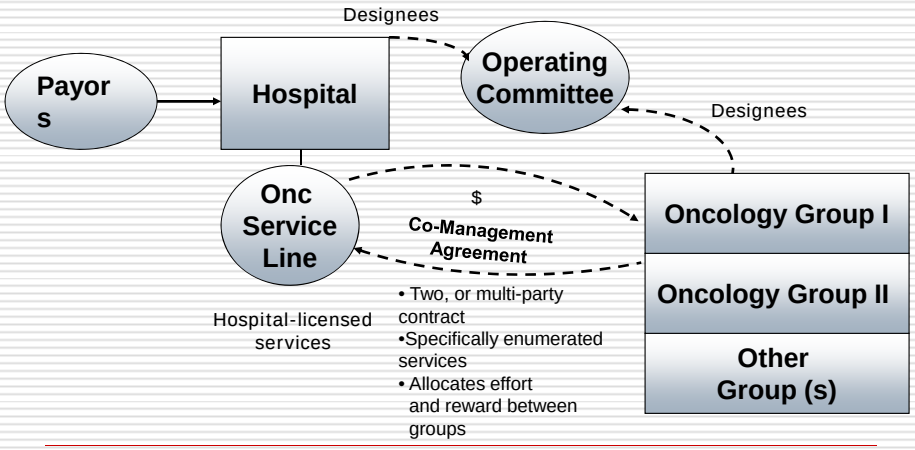
Hybrid PSA/Service Line Co-Management Arrangements

What is a Service Line Co-Management Arrangement?

- Independent contract relationship
- Between Hospital and Group(s)/physicians, or between Hospital and a joint venture LLC comprised of Hospital and Group(s)/physicians
- Focused on a Hospital's oncology service line
  - Scope?
- To engage physicians as a partner in managing, overseeing and improving service line quality and efficiency

Service Line Co-Management Direct Contract Model



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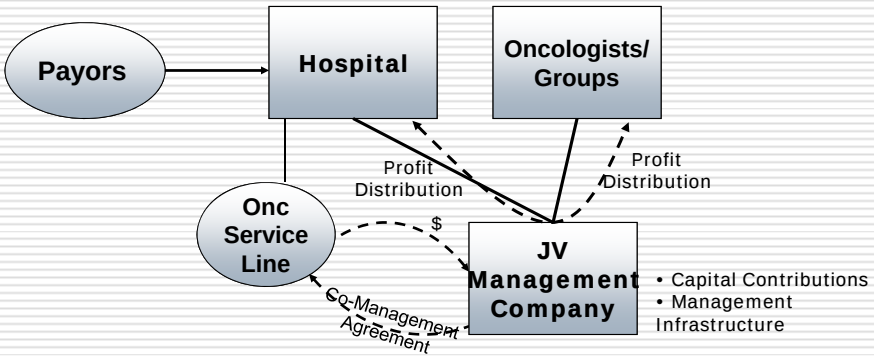
Service Line Co-Management Joint Venture Model



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Service Line Co-Management Arrangements

- Typically two levels of payment to physician managers:
  - Base fee – a fixed annual base fee that is consistent with the fair market value of the time and effort participating physicians dedicate to service line development, management, and oversight
  - Bonus fee – a series of pre-determined payment amounts, each of which is contingent on achievement of specified, mutually agreed, objectively measurable, program development, quality improvement and efficiency goals
  - Aggregate payment generally approximates 2-6% of service line revenues expressed as fixed FMV fee; independent appraisal advisable

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Sample Medical Oncology Performance Standards

- Comply with NCCN/QOPI guidelines
- Increase in patient satisfaction
- Increase in staff satisfaction
- Decrease in infusion site infections
- Substitution of lower cost drugs/items for drugs/items of equivalent efficacy and quality
- Increase in patient accruals for hospital clinical trials

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Sample Medical Oncology Performance Standards

- Increase in percentage of patients with written treatment plans at start of infusion
- Increase in percentage of written treatment plans with indication of:
  - Staging
  - Intention of therapy
  - Approved treatment regimen for tumor site/staging
- Increase in percentage of written treatment summaries at completion of course of treatment

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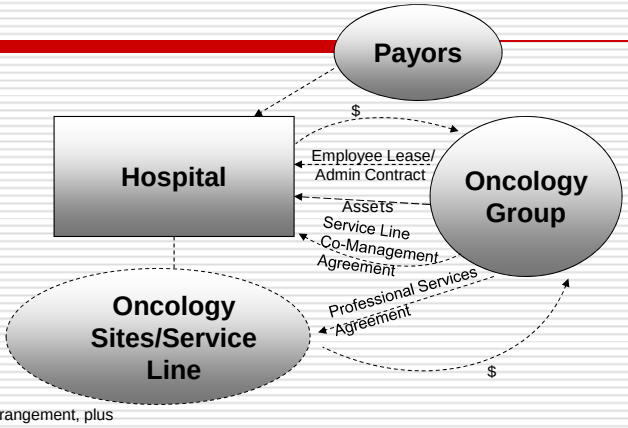
PSA with Service Line Co-Management Agreement



Notes:
- Same as PSA arrangement, plus
- Service Line Co-Management Agreement
  - PSA component – wRVU rate equal to aggregate current physician comp/benefits
  - Asset/inventory purchase
  - Employee Lease/Administrative Contract – Fixed fee, cost plus or percent of collections with FMV floor and cap
  - Co-management base component – fixed fair market value fee
  - Incentive component contingent on meeting specified quality and efficiency improvement standards – fixed FMV fee per standard

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Regulatory Considerations

- There are legal constraints on Service Line Co-Management Agreements (i.e., Stark, CMP, and AKS):
  - No stinting
  - No steering
  - No cherry-picking
  - No gaming
  - No payment for changes in volume/referrals
  - No payment for quicker-sicker discharge
  - No reward for changes in payor mix, case mix
  - Must be FMV; independent appraisal strongly advised

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Key Service Line Co-Management Issues

- Additional work for already busy physicians
- Scope of service line under management
  - Service line co-management services
  - No overlap with, e.g., PSA, employee lease, Medical Director agreement or other agreements
- Performance standards and targets
  - Validation
  - Achievability
  - Reset

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Key Service Line Co-Management Issues

- Operating Committee composition and authority
- Term/durability
  - Rev. Proc. 97-13 (5/3 years if 50%+ fixed)
- Dilutive effect of adding physicians due to fixed FMV fee for services rendered
- Cost of independent monitor, valuation, security offering (for JV)
- Some irreducible legal risk

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Key Deal Maker/Breaker Issues

- Governance
- Financial Terms
- Term/Duration
- Termination
- Restrictive Covenants
- Unwind/Unwind Rights
- Addition of New Physicians
- Buy-In/Buy-Out Rights (if applicable)
- First Opportunity
- Arbitration/Dispute Resolution

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Conclusions and Strategic Options for Oncologists

National Health Reform

- ACA begins to change payment/delivery paradigm
  - Rewards value instead of volume
    - Value based purchasing, shared savings, gainsharing, bundled payments, EOCs, capitation
  - Coordinate care among and across providers
    - ACOs, medical homes, home based chronic care management, community health teams, health care innovation zones
    - New structures promoting integration

Strategic Options For Oncologists

- Do nothing
- Become an ACO participant in a local/regional ACO and obtain proportionate role in governance/decision-making
- Apply to CMMI for an innovation grant for an oncology-only ACO or other initiative
- Form an oncology supergroup under a single tax id number Form "strong" oncology IPA for risk-contracting
- Join a sizable multi-specialty group with a strong primary care base and become a physician-centric ACO/Medical Home
- Form an Oncology Medical Home and try to be indispensible to all ACOs and PCMHs

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Strategic Options For Oncologists

- Clinically integrate with a Hospital/IDS/ACO (e.g., through PSA/Co-management arrangements)
- Sell practice and become employed by a Hospital/IDS/ACO
- Become part of a staff model HMO or payor affiliate
- Concierge oncology?

Engage in care transformation planning internally and with preferred partners to deliver new value proposition

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Oncology Medical Home

- Consultants in Medical Oncology
- NCQA Level 3 Oncology Medical Home
- Care coordination; value and evidence-based, pro-active care
- Hand-off from PCMH when primary diagnosis is cancer, through survivorship
- Patient registry
- Nurse telephone triage

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Oncology Medical Home

- Standardization of patient assessment, treatment protocols, collection of data, documentation, patient navigation
- Emergency department visits per chemo patient reduced from 2.6 in 2004 to 0.91 in 2010
- Hospital admissions per chemo patient reduced to 0.6
- Documentation turnaround reduced from 28 to less than 1 day
- End-of-life care planning reduces chemo use/visits by 12% and increase in the average hospice LOS from 26 days to 32 days
- Measurable patient outcomes not adversely affected
- Key is getting payors to pay more for fewer services/better value

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ACO Contracting: Key Terms

- Service level
- Payment method and rate
- Timing of payments
- Upside/downside risk?
- Performance standards/performance payments
- Timing of reconciliation/final payment
- Deep pocket guarantee?
- Term/termination
- Restrictive covenants
- Compliance with ACO requirements (e.g., can't require in-network referrals)
- Access to records and audit right
- Dispute resolution process

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QUESTIONS?

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