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Aligning Oncologist-Hospital Interests Through Co-Management Arrangements

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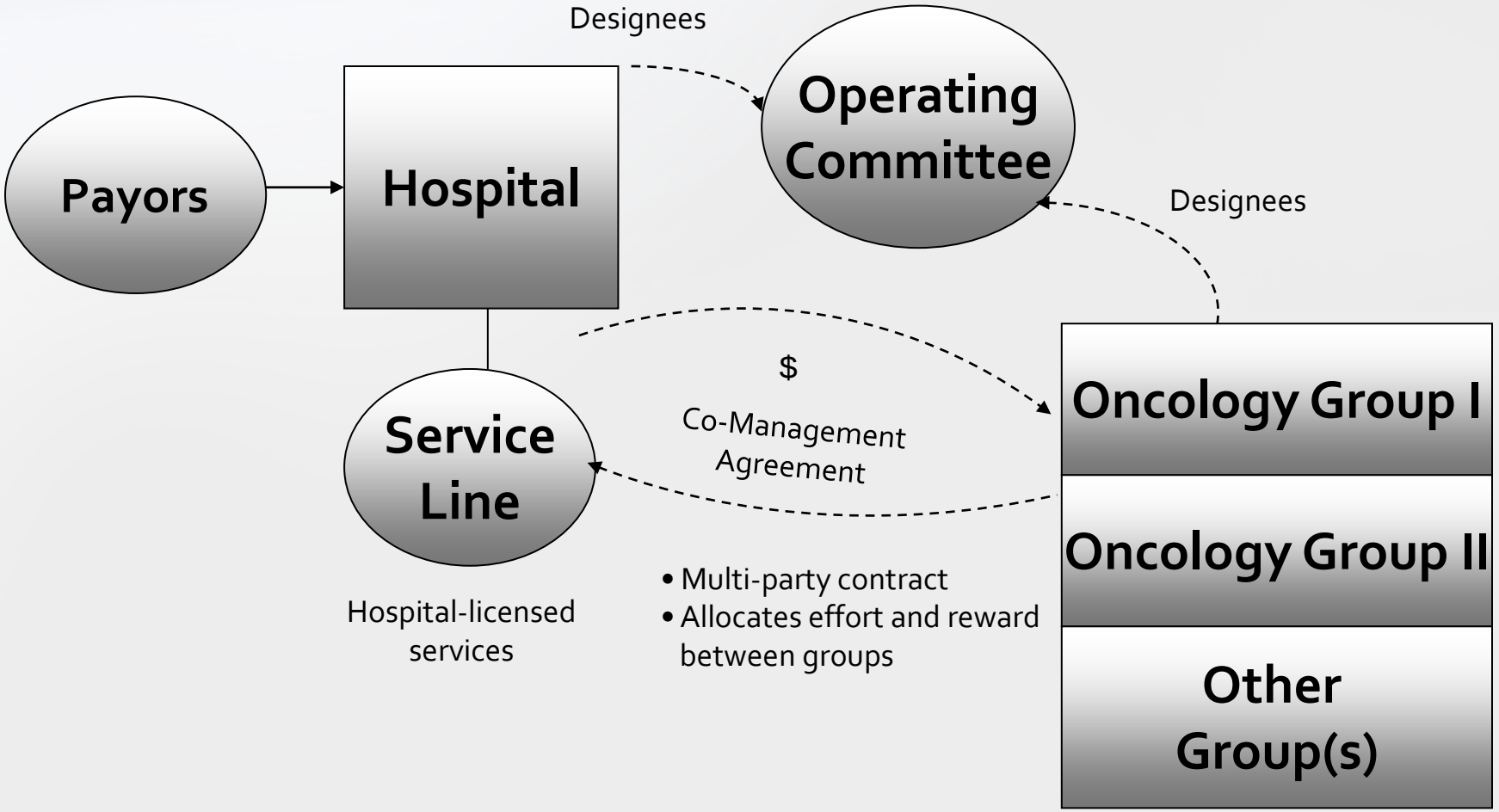
Service Line Co-Management Arrangements

The purpose of the arrangement is to recognize and appropriately reward participating medical groups/physicians for their efforts in developing, managing, and improving quality and efficiency of the hospital's oncology service line.

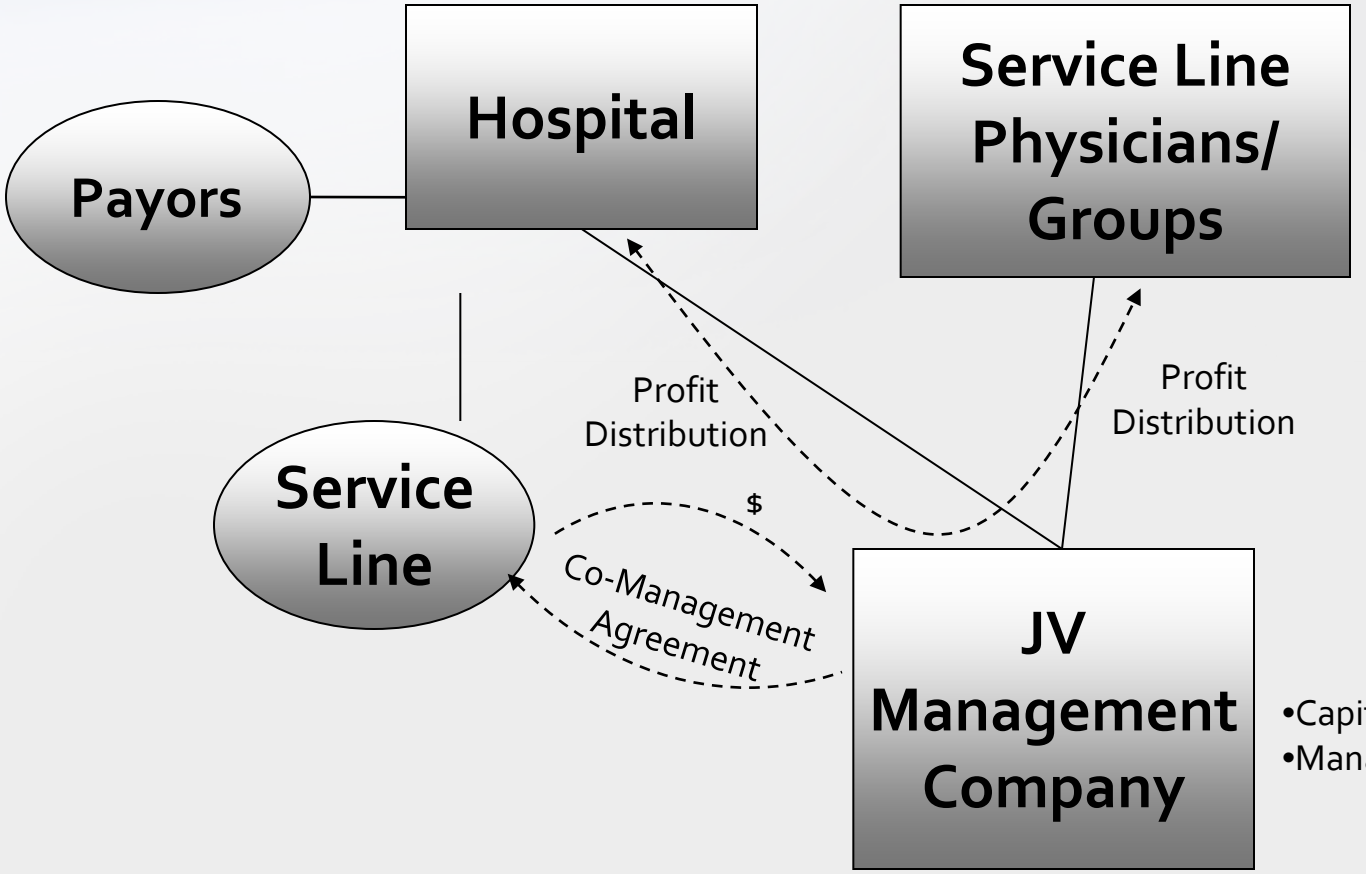
Co-Management Arrangement Structural Considerations

- The "management entity" may be a single existing physician practice, or a new entity ("NewCo") may be created consisting of multiple physicians and/or physician practices
- The hospital may or may not have an ownership interest in NewCo

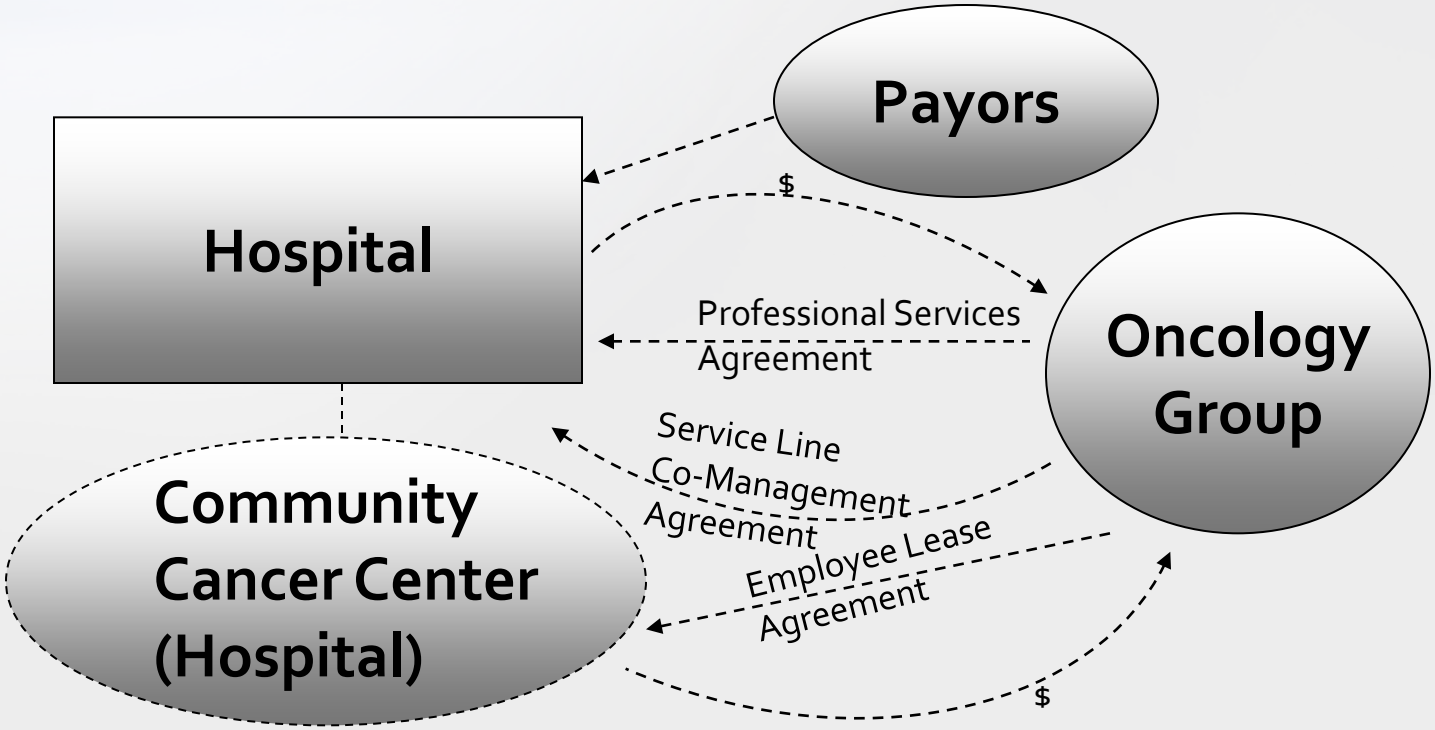
Service Line Co-Management Direct Contract Model



Service Line Co-Management Joint Venture Model



PSA with Service Line Co-Management Agreement



Notes:

- Service Line Co-Management Agreement (3-6% of Service Line revenue, which can be of both cancer center and hospital)
  - PSA component –RVU rate equal to aggregate current revenue
  - Co-management component – fixed fair market value fee
  - Incentive component contingent on meeting specified quality and efficiency improvement standards – fixed FMV fee per standard

Service Line Co-Management Arrangements

There are typically two levels of payment to oncologists under the service line contract:

- Base fee – a fixed annual base fee that is consistent with the FMV of the time and efforts participating oncologists dedicate to the service line development, management, and oversight process
- Bonus fee – a series of pre-determined payment amounts contingent on achievement of specified, mutually agreed, objectively measurable, program development, quality improvement and efficiency goals

Service Line Co-Management Arrangements

- Pays participating oncologists 3-6% of service line revenues
  - Fixed, fair market value fees; independent appraisal advisable
- Base payment relates to scope of service line
  - Outpatient oncology
  - Inpatient oncology
  - Dedicated oncology ancillaries: pharmacy, lab, imaging
  - Radiation oncology
  - Surgical oncology
- Base pay relates to service line duties

Service Line Co-Management Arrangements

Sample Co-Management Services (select)

- Development of service line
- Medical director services
- Budget process
- Strategic/business planning process
- Community relations and education
- Patient, physician and staff satisfaction surveys
- Development of clinical protocols and performance standards

Service Line Co-Management Arrangements

Sample Co-Management Services (cont.)

- Ongoing assessment of clinical environment and work flow processes
- Physician staffing
- Patient scheduling
- Staff scheduling and supervision
- Human resource management
- Case management activities (*e.g.*, discharge planning, arranging follow-up services and supplies, call back processes)

Service Line Co-Management Arrangements

Sample Co-Management Services (cont.)

- Materials management
- Medical staff-related activities and committee participation
- Credentialing assistance
- Coordination with the reporting to hospital

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

Sample Medical Oncology Performance Standards

- Improved on-time infusion/RT starts
- Improved turn-around time for infusion chair/RT
- Compliance with QOPI/PQRI standards
- 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

Principal Regulatory Considerations

- Civil Monetary Penalty Statute
  - No stinting: can't pay for reduction in LOS or for generalized cost savings
  - Limited gainsharing permitted: substitution of lower cost items of equivalent quality
- Anti-Kickback Statute
  - No payment for referrals
  - No payment to change case mix, payor mix
  - Not safeharbored: aggregate compensation not set in advance

Principal Regulatory Considerations

- Physician Self-Referral Statute (Stark)
  - Direct contract model: Fair Market Value exception
  - JV Model: indirect compensation exception (or structure to avoid Stark)
- False claims Act
- Tax Exemption/Intermediate Sanctions
  - Reasonable compensation limitation
  - Rev. Proc. 97-13 durational limitations

Principal Regulatory Considerations

- Provider-Based Status Rules
  - Clinically, financially and administratively integrated with hospital/hospital reporting lines
- Securities laws
  - JV offering to non-accredited investors

Regulatory Considerations

- Legal constraints on Service Line Co-Management Agreements
  - No stinting
  - No steering
  - No cherry-picking
  - No gaming
  - No payment for changes in volume/referrals
  - No payment for quicker-sicker discharges
  - Must be FMV; independent appraisal required
- Proposed Stark Law Exception for Incentive Payment and Shared Savings Programs

Additional PSA Regulatory Considerations

- Medical provider-based status rules
  - Cannot lease mid-level providers to hospital for off-campus facilities (more than 250 yards from main campus)
- Stark Law
  - In-Office Ancillary Services Exception – 75% of patient care services billed through group
    - Hospital services provided under PSA counted toward 75% test even though billed by hospital (otherwise not more than 25% of services could be billed under PSA if group continues to provide and bill for any in-office ancillaries)

Service Line Co-Management Arrangements

Other Considerations:

- Commits 3-6% of service line revenues
- Requires active participation and real time and effort by busy physicians
  - Documentation requirements
- Allocation of fees among participating oncologists
- Durability: need to periodically adjust performance standards and targets?
  - Will the parties reach agreement/dispute resolution?

Service Line Co-Management Arrangements

- Dilution by adding physicians
- Physicians may not share in reward from growth of service line
- Physician entity to organize participating physicians and allocate payments?
- Cost of independent appraisal (and clinical monitor)
- Legal costs
- Some irreducible legal risk

Co-Management Arrangements
FMV Considerations

- Compliance with FMV is critical for regulatory compliance, but also for the ultimate success of the project.
- FMV compensation payable under a co-management arrangement is particularly subjective.
- As with other *management agreements*, the physician managers are not compensated based upon hours worked; compensation is based upon a specific set of management duties and desired performance metrics.

Co-Management Arrangements
FMV Considerations

- The physicians are expected to provide those specific duties outlined in the co-management agreement.
  - Skeptics may say that there is a risk of overcompensating physicians' contributions to co-management arrangements.
- One means of valuing a co-management fee is by comparison to other management arrangements (*e.g.*, ASC management or practice management).
  - Such management entities are expected to devote required time and resources to their management obligation, and there is little opportunity for the manager to "hide".
- Specifically identified medical directors can still exist (and be compensated), but the medical director roles must be integrated with the overall financial analysis of the program.

Co-Management Arrangements Establishing FMV

- Available valuation methodologies are limited and somewhat subjective.
- In considering the primary valuation approaches (cost, income and market), an income approach can likely be eliminated.
- Using a cost approach, FMV of the management fee can be established by assessing the estimated number of work hours needed to provide the management services multiplied by a FMV hourly rate.
  - However, the exact number of required work hours cannot reasonably be determined in advance.
- Further, a key ideal of most co-management arrangements is to reward *results* rather than time-based efforts.

Co-Management Arrangements
FMV Considerations

- A market approach recognizes that each co-management arrangement is unique, and considers specific market and operational factors related to the subject arrangement.
  - Break the specific services down into specific tasks and objectives, and then compare to other arrangements.
  - On an item-by-item basis, assess the relative worth of each task/objective, and determine necessary adjustments to the comparable arrangements.
- The cost and market valuation methodologies described above must be reconciled to arrive at a final conclusion of value. Consistency in approach aids in supporting the FMV of subjective compensation arrangements.
- The FMV of the *total management fee* must be established, as well as the *base* and *incentive* components.

Co-Management Arrangements
Valuation Expectations

- Management fee equals 3-6% of service revenues? "So which one is it? 6% sounds better than 3%!"
- Key determinates of the FMV compensation:
  - Size (*e.g.*, net revenue) of the service line being managed
  - Complexity of the service line being managed
  - Extent and scope of services being provided
  - Service line maturity and opportunities
  - Unique attributes/considerations
  - Valuator's judgment and experience

Other FMV Considerations

- Integration with other agreements:
  - Clinical staffing agreements
  - Call/coverage agreements
  - Medical directorship agreements
  - Department/division chair agreements
  - Physician lease/lease-back agreements
- Allocation of value among participating physicians/medical groups
- Engagement of valuator by counsel to obtain benefit of attorney-client privilege?

Co-Management Arrangements
FMV Pitfalls/Issues

- No independent FMV analysis was obtained.
- The government fails to find the FMV analysis compelling.
- A retrospective review of facts and circumstances may cast the arrangement in a poor light (*e.g.*, if there is no record of active physician involvement, notwithstanding the fact that hours are not tracked).

Practice Acquisitions

Two primary approaches:

- Practice purchase price equals tangible asset value, and future compensation to the physicians is unencumbered by the purchase transaction.
- Practice purchase price includes value for specifically identified intangible assets (*e.g.*, workforce in place, trade name), but future compensation to the physicians must be consistent with past practices, or the purchase price must be reduced.

"Synthetic" Employment Agreements aka PSA Models

- Instead of employment, new arrangements are gaining traction whereby oncologists retain their own practice, and are compensated on a productivity basis (*e.g.*, per wRVU) for their clinical services.
- A transaction may involve the purchase of the oncologists' tangible assets and payment for workforce in place (or an employee leasing arrangement).
- The wRVU rate payable to the oncology group is a "gross" rate that includes remuneration for:
  - cash compensation;
  - taxes and benefits; and
  - "retained" practice expenses (*e.g.*, malpractice insurance, CPE costs, etc.)
- The FMV analysis should consider pre- and post-transaction compensation to the physicians.

FMV Considerations in Employment and PSA Arrangements

- Compensation "stacking"
  - Medical director fees
  - Management fees
  - Administrative fees
  - Quality bonuses
  - Sign-on bonuses
  - Retention bonuses
  - Tail coverage, etc.
- Consider that the data reported by the compensation surveys generally include all sources of income.
- Sources of compensation survey data:
  - Medical Group Management Association (MGMA)
  - Sullivan Cotter & Associates
  - Hospital & Healthcare Compensation Service
  - American Medical Group Assn (AMGA)
  - Towers Watson Data Services (fka Watson Wyatt)

FMV Considerations in Employment/PSA Arrangements

- Confucius Statistician say…If you torture the data long enough, it will confess to the crime it did not commit.
- For oncology/hematology in particular, available market data are somewhat schizophrenic.
  - Are survey respondents reporting data in a consistent manner (*e.g.*, total collections vs. professional collections)?
- MGMA data can be misused in a variety of ways, including:
  - Cherry picking from among different tables (*e.g.*, regional data vs. state data)
  - 90th percentile compensation times 90th percentile wRVU productivity
- Failure to consider ownership/ancillary profits that may be inherent in 90th percentile compensation

MGMA Data Anomalies

For Hematology/Oncology:

- 90th percentile cash compensation - $784,000
- 90th percentile wRVUs – 7,905
- 90th percentile compensation per wRVU - $127

Where is this going?

- 90th percentile wRVUs x 90th percentile compensation per wRVU = $1,004,000
- MGMA states that there is an inverse relationship between physician compensation and compensation per wRVU
- *Median* compensation (per wRVU) is a misnomer; no physician wants to be below the median!

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