

ONCOLOGY: STRATEGIES FOR SUPERIOR SERVICE LINE PERFORMANCE



ECG MANAGEMENT CONSULTANTS, INC.

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Kathryn K. Reed, a manager at ECG, has broad experience in strategic planning, financial analysis, service line development, hospital/physician alignment, and transactions. She has expertise in oncology services and has worked with a variety of clients on their service line and programmatic needs. Most recently, Reed facilitated several hospital/physician transactions, including the acquisition of an independent oncology group. She has substantial experience developing alignment models, designing funds flow and governance structures, conducting fair market value assessments, evaluating the 340B Drug Pricing Program and provider-based conversions, supporting physician practice valuations, facilitating hospital/physician negotiations, and providing ongoing integration assistance. Reed holds a master of business administration degree from the University of Washington Michael G. Foster School of Business and a bachelor of science degree in biology from The University of Texas at Austin.

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ECG's Oncology Affinity Group is responsible for the thought leadership and knowledge development of the firm's oncology practice. The group has extensive

experience in strategic planning, operations improvement, hospital/physician transactions, and reimbursement optimization in oncology services. In addition to the authors, key contributions were made by the following members of the group:

- **James P. Donohue, senior manager**, has more than 17 years of experience in the healthcare industry working with major medical centers, with a focus on business operations and strategic planning, oncology reimbursement strategies, and contracting.
- **Krista L. Fakoory, manager**, has extensive experience in operations and process improvement, genetic and disease research, and business development. Fakoory has assisted in the development of oncology service line management and governance structures, performed fair market value assessments, and participated in strategic planning for clinical research programs.
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- **Stephen F. Messinger, principal**, has worked with a broad range of health-care organizations and has assisted hospitals, health systems, and physician groups in cancer strategy development and performance improvement. Messinger has led large oncology transactions and service line development projects.
- **Katherine Collings Ray, senior consultant**, has assisted community hospital and medical group clients in evaluating and implementing the 340B Drug Pricing Program and determining optimal alignment structures in oncology specialties.
- **Malita I. Scott, manager**, has focused her career on oncology service line development and operations improvement. Scott has served as project manager for the development of new multidisciplinary cancer institutes, assisted with the completion of numerous operational improvement initiatives in hospitals and physician practice settings, performed multiple compensation planning and fair market value assessments, and evaluated clinical research programs for adherence to regulatory and financial guidelines.

About ECG



ECG offers a broad range of strategic-, financial-, operational-, and technology-related consulting services to healthcare providers. As a leader in the industry, ECG provides specialized expertise to community hospitals, academic medical centers, health systems, and medical groups. For nearly 40 years, its more than 110 consultants have played an instrumental role in developing and implementing innovative and customized solutions that effectively address issues confronting healthcare providers. ECG has offices in Boston, San Diego, San Francisco, Seattle, St. Louis, and Washington, DC.

At the heart of its expertise in oncology services is an understanding of the competencies needed to differentiate top-performing oncology service lines. ECG has had the pleasure of working with premier oncology programs, helping hospitals and physicians work together to build and develop service line strategies and structures.

The Evolution and Adoption of Cancer Service Lines

In the four decades since President Richard Nixon announced a “total national commitment for the conquest of cancer” while signing into law the National Cancer Act, incredible progress has been made in understanding the fundamental nature of cancer and translating those findings into prevention and treatment of the disease. The result has been a dramatic increase in the likelihood of survival for cancer patients and a better quality of life for survivors. Since the 1970s, cancer survival rates have improved significantly (see Figure A), resulting in an estimated 898,000 fewer cancer deaths during the period of 1991 through 2007.¹

Although these developments have been nothing short of remarkable, cancer remains the second leading cause of death in the United States (see Figure B), and cancer incidence is expected to increase sharply over the next 20 years as the U.S. population continues to grow and age.²

Research has also shed light on the complex nature of cancer. In fact, it is no longer possible to discuss cancer as a single disease, but as a collection of “more than 200 diseases—all of which have different causes and require different treatments.”³

FIGURE A
TRENDS IN FIVE-YEAR RELATIVE SURVIVAL RATE

Tumor Site	1975 to 1977	1999 to 2006
Breast (female)	75%	90%
Colon	52%	66%
Leukemia	36%	55%
Lung and bronchus	13%	16%
Melanoma	83%	93%
Non-Hodgkin's lymphoma	48%	69%
Ovary	37%	45%
Pancreas	3%	6%
Prostate	69%	100%
Rectum	49%	69%
Urinary bladder	74%	81%
All sites	50%	68%

Source: American Cancer Society. (2011). *Cancer Facts & Figures 2011*. Atlanta: American Cancer Society.

The Players

The same complexity that defines cancer at a molecular level is reflected in the array of specialists and healthcare providers required to treat patients, as well as the business models required to bring these disparate providers together to function as a cohesive unit. Typically, oncology providers belong to multiple,

FIGURE B
UNITED STATES LEADING CAUSES OF DEATH—2007

Rank	Cause of Death	2007 Annual Number of Deaths	Percentage of All Deaths—2007
1.	Heart disease	616,067	25.4%
2.	Cancer	562,875	23.2%
3.	Cerebrovascular disease	135,952	5.6%
4.	Chronic lower respiratory disease	127,924	5.3%
5.	Accidents (unintentional injuries)	123,706	5.1%
6.	Alzheimer's disease	74,632	3.1%
7.	Diabetes mellitus	71,382	2.9%
8.	Influenza and pneumonia	52,717	2.2%
9.	Nephritis	46,448	1.9%
10.	Septicemia	34,828	1.4%

Source: National Center for Health Statistics, Centers for Disease Control and Prevention. (2010). *U.S. Mortality Data 2007*. Atlanta: Centers for Disease Control and Prevention.

independently operating entities, each with their own, often competing, clinical, financial, and political concerns. This disparity among providers results in complicated relationships between individual providers and organizations, making coordination of care especially difficult. Figure C explores several key characteristics of each type of provider involved in the oncology treatment team.

FIGURE C
THE ONCOLOGY TREATMENT TEAM: KEY CHARACTERISTICS

Specialty/ Service	Description	Practice Overview	Referral Patterns	Power/Influence on Team
Medical oncology	<ul style="list-style-type: none"> Medical specialty that concentrates on oncology treatment with medications (e.g., chemotherapy, analgesics, hormones) 	<ul style="list-style-type: none"> Most care is delivered in an outpatient setting Chemotherapy infusions represent both a key treatment modality and income source Thereby, medical oncologists are exposed to risks associated with Medicare’s decreasing reimbursement for medications and high drug costs* Increasingly, private practices are transitioning to hospital employment given changes in reimbursement 	Often thought of as the oncology coordinator of care (“gatekeeper”); in reality, they are not exclusively gatekeepers	<ul style="list-style-type: none"> High Medical oncologists oversee patient care from diagnosis through treatment and often beyond as managers of survivorship care.

FIGURE C

THE ONCOLOGY TREATMENT TEAM: KEY CHARACTERISTICS (CONT.)

Specialty/Service	Description	Practice Overview	Referral Patterns	Power/Influence on Team
Surgical oncology	<ul style="list-style-type: none"> • Surgical specialty with clinical experience concentrated in tumor excisions • Surgical subspecialization includes breast, cardiothoracic, neurology, and gastroenterology, among others 	<ul style="list-style-type: none"> • The majority of surgical oncology services are provided in a hospital setting • Historically, a higher percentage of surgeons were employed by hospitals than other oncology subspecialties 	Surgical oncologists are key referral sources for radiation oncology; referrals to surgical oncology may come from a variety of sources	<ul style="list-style-type: none"> • Medium • Surgical oncology patients will typically require other oncology services and treatment for comorbidities, so the surgeons are important members of the oncology team

FIGURE C
THE ONCOLOGY TREATMENT TEAM: KEY CHARACTERISTICS (CONT.)

Specialty/ Service	Description	Practice Overview	Referral Patterns	Power/Influence on Team
Radiation oncology	<ul style="list-style-type: none"> Medical specialty that uses radiation therapy in the treatment of cancer 	<ul style="list-style-type: none"> Most care is delivered in an outpatient setting Radiation therapy requires a significant financial investment in technology (e.g., linear accelerator), but in return, it is also the driver of revenue Radiation oncologists are exposed to risks associated with Medicare's trend in decreasing reimbursement for their services** 	Typically, radiation oncologists account for limited referrals to other clinicians	<ul style="list-style-type: none"> Medium Radiation oncologists often play a smaller role in program building/development than do medical or surgical oncologists However, technical income from radiation oncology is often used to support other elements of the oncology program, making the service clinically, financially, and strategically important to the program

FIGURE C
THE ONCOLOGY TREATMENT TEAM: KEY CHARACTERISTICS (CONT.)

Specialty/ Service	Description	Practice Overview	Referral Patterns	Power/Influence on Team
Support services	Interdisciplinary patient care often includes a variety of nonallopathic services, such as nutrition education, physical therapy, occupational therapy, and social worker counseling	<ul style="list-style-type: none"> • Services may be provided to inpatients and outpatients • Providing the support services alone is typically not financially viable because they may not be eligible for payer reimbursement 	Support services are dependent on referrals from physicians	<ul style="list-style-type: none"> • Low • Support services typically have the least influence on the oncology team

FIGURE C
THE ONCOLOGY TREATMENT TEAM: KEY CHARACTERISTICS (CONT.)

Specialty/ Service	Description	Practice Overview	Referral Patterns	Power/Influence on Team
Diagnostic services	<ul style="list-style-type: none"> • <i>Imaging</i> – Technology used to identify and assess a patient’s condition. Modalities include x-ray, CT scan, MRI, ultrasound, and nuclear medicine • <i>Laboratory</i> – Studies performed to assist in the management of patient care, such as blood diagnostics and pathology reports 	<ul style="list-style-type: none"> • Imaging and laboratory services are provided to inpatients and outpatients • Reimbursement for imaging services is currently being heavily scrutinized and will likely experience further reductions 	Diagnostic services are dependent on referrals from physicians	<ul style="list-style-type: none"> • Low • Diagnostic services do not directly manage a patient’s therapeutic regimen, but they are essential to comprehensive, multi-disciplinary care and programmatic economic viability

* See Chapter 6 for more discussion on Medicare reimbursement changes.

** For example, there have been recent Medicare changes to the radiation oncology practice expense methodology. See Chapter 6 for more reimbursement trends.

Source: ECG Management Consultants, Inc.

Given the nature of the disease (or, more appropriately, diseases) and the challenges associated with bringing together a diverse group of providers, it is not surprising that the market for oncology services is, more often than not, characterized by inconsistent access to care, limited coordination among providers, frequent variability in treatment, and redundancy/waste in the system due to the provision of duplicative services. At the same time, payers, most notably Medicare, struggle with how to cover the rising costs of cancer care. In recent years, Medicare has adopted strategies to both provide immediate savings (e.g., cutting payments to providers) and longer-term systematic change through a number of innovative payment mechanisms (e.g., accountable care organizations, bundled payments, pay for performance).

The Programs

The evolution of the oncology payment model is leading many healthcare organizations to transform the oncology care model in their communities by offering more coordinated and comprehensive services that provide high quality for patients and high value to payers. Many hospitals are developing oncology service line structures that have the potential to improve clinical and financial performance, encourage physician involvement, create a distinct brand in the market, and ultimately gain a competitive advantage. While implementation of an oncology service line varies widely among hospitals, there is broad agreement that this type of is necessary for success.

Based on decades of work with a wide range of oncology providers, from small private practices to National Cancer Institute–designated cancer centers, our

experience indicates that successful oncology service lines typically share the following characteristics:

- **Facility and identity:** The service line has a facility or center where all cancer services can be presented to patients in a coordinated manner. The service line also has a brand name and image that is identifiable by patients and physicians in the community.
- **Coordination:** Clinical services are delivered seamlessly throughout the continuum of cancer care. As patients progress through each phase of treatment, providers share information to better inform the course of treatment, prevent unnecessary duplication of services, and ensure adherence to evidence-based oncology practice guidelines across different specialties and sites of service.
- **Clinical programs:** Differentiation occurs through the development of multidisciplinary tumor-site-specific programs, typically focusing on one, or all, of the most common cancer tumor sites (i.e., breast or lung). A fully developed clinical program operates with dedicated staff and support resources and is often marketed as a featured component of the oncology program. In order to provide tumor-specific expertise, successful programs attract providers who are highly qualified and experienced in treating tumor-specific cancer sites.
- **Clinical trials:** Clinical trials enable patients to have access to treatment options that may be beneficial but are still in experimental phases. A robust research program may be a key asset to recruiting both patients and clinicians to the program.

- **Support services:** A full range of psychosocial support services (e.g., patient navigation, mental health and social work, financial counseling) are offered to complement diagnostic and treatment services. These services are integral to the provision of high-quality patient care, and leading programs are those able to proactively identify and match patients to the services offered.
- **Technology:** State-of-the-art technology is used in the diagnosis and treatment of patients. This includes the implementation of electronic medical records and health information exchanges, which facilitate the flow of clinical information and enhance decision-making among providers.
- **Access:** Services are easily accessible and provided in a patient-centric setting. Colocating a range of diagnostic, treatment, and support services improves access and provides physical and psychological benefits to patients.
- **Physician governance:** Well-performing oncology programs have a well-defined physician governance organization that incorporates physicians into policy and strategy setting activities, enabling the physicians to have a meaningful role in charting the direction for the program.

The remainder of this book provides details regarding the creation and operation of a successful oncology service line. The content of the chapters was designed to allow quick access to topics of special interest to the reader.

References

1. American Cancer Society. (2011). *Cancer Facts & Figures 2011*. Atlanta: American Cancer Society.
2. American Association for Cancer Research. (2011). *Cancer Progress Report 2011: Transforming Patient Care Through Innovation*. Philadelphia: American Association for Cancer Research.
3. Ibid.

Key Elements of a Successful Oncology Transaction

Having completed the initial physician alignment planning, hospital and physician leadership are ready to begin defining the details of the arrangement. While the parties may agree on an overall approach, the negotiation of transaction details can reveal challenges and disagreements that will need resolution. Taking the time to systematically work through the various deal points is critical to long-term success; however, it is not unusual for hospitals to rush the transaction process to meet a perceived crisis or artificial deadline. It is in these situations that obstacles can emerge that may disrupt negotiations and ultimately stall or derail the transaction process.

Ultimately, the details of the alignment model must reflect the unique needs of the players and the particular market. Despite their range in design and complexity, transactions that are successfully completed typically utilize a fairly standard method to work through the various issues and deal points. This chapter outlines an effective process for these discussions and highlight the key trends that have emerged in oncology transactions.

Definition of the Transaction Goals

Cancer programs and physicians should focus on defining critical success factors for the transaction. Most importantly, the oncology program and the physicians will need to establish how physicians will be rewarded for their contributions. For example, hospitals frequently see acquisitions as part of a strategy to expand services available to the community and enhance or protect market share. Compare this to medical groups' dominant objective of protecting the compensation and lifestyle of their physician shareholders. Reaching concurrence on both shared and unilateral objectives will ensure that both parties' needs can be met.

The transaction goals and objectives, in combination with the affiliation objectives (defined in Chapter 4), will serve as the evaluation criteria to determine an appropriate model and can also help guide the first discussions. However, it is important to expand on these initial objectives when evaluating what each party hopes to achieve through the actual transaction negotiation. For example, physicians may have disparate opinions about the level of risk or types of incentives they want in their compensation plan, while the hospital has limitations on the types of compensation models that can be used legally. Regardless, it is important to determine which terms are most important to each party before engaging in detailed discussions. Depending on the group's particular dynamics, this process could be initiated through individual stakeholder interviews or focus groups and then shared with a broader steering committee of hospital and physician representatives; alternatively, the committee could jointly evaluate its goals for alignment. Thinking through the various issues early on will help frame the discussion and ensure that there is consensus on an overall shared direction. If consensus cannot be reached on vision

and priorities for the relationship, it makes sense to explore alternatives to affiliation discussions.

Evaluate Business Implications

Once the objectives of the transaction are agreed to, organizations tend to rush through negotiations in an attempt to quickly finalize an agreement. Even in the most urgent circumstances, it is important to utilize a structured process that will facilitate informed and shared decision-making while avoiding impulsive decisions that can ultimately stall discussions. Determining the basic feasibility of the relationship from a business perspective should be completed very early in discussions.

The conclusions and recommendations resulting from determining the business needs of the parties will provide a common understanding of the imperatives for alignment and help steer negotiations, particularly as the key deal points for an arrangement become finalized.

Some consideration should be given to the following aspects of alignment:

- How does this arrangement assist the aligned organization's overall vision for the future of how oncology care is delivered in its market?
- Does this arrangement support the hospital's broader physician alignment strategy?
- Will the arrangement facilitate greater clinical coordination and improve efficiency?

- Are provider needs for competitive compensation and stability addressed?
- Will this arrangement support the community need for oncology services and subspecialty care?
- What should a true partnership involve?
- Are physicians willing and ready to help lead the oncology service line?
- What are “deal breakers” from each party’s perspective?

Understand key drivers

The incremental costs associated with hospital/physician alignment often require that parties identify additional revenue streams, either through increased volume or better reimbursement. Financial challenges are particularly significant in oncology-related services because many independent physicians rely on ancillary services for a substantial percentage of their income. (See Figure 5.1 for some potential considerations in the areas of strategy and finance.) In addition, many of these alignment arrangements require large up-front capital expenditures, whether it be to assume the drug inventory of a medical oncology business or to purchase a radiation oncology group’s linear accelerators and other related equipment.

To generate new revenue, many hospitals are seeking to convert all or portions of physician practices to provider-based designation. Under provider-based status, physicians receive a reduced Medicare professional fee for selected services, while the employing hospital can bill for overhead expenses. The hospital bills a facility fee to cover the practice costs, which typically exceeds the reduction in

FIGURE 5.1
STRATEGIC AND FINANCIAL CONSIDERATIONS

Strategic	Financial
<ul style="list-style-type: none"> • Community supply issues • Competitor and community response • Positioning for potential reform changes • Strategic and programmatic growth of key services • Medical staff reactions, particularly independent oncologists • Physician recruitment and retention 	<ul style="list-style-type: none"> • Oncology margin gains (e.g., ancillary and outpatient revenue) • Potential reimbursement changes • Payor reactions • Impact on referral streams • Incremental operating expense (e.g., information technology) requirements • Infrastructure needs

Source: ECG Management Consultants, Inc.

professional fees and can result in a reimbursement advantage, particularly for select oncology services. Even if the Medicare reimbursement differential is insubstantial, the conversion of oncology services to provider-based status can have a considerable commercial reimbursement advantage.

Another approach to enhancing margins is acquiring chemotherapy drugs through the 340B Drug Pricing Program. The 340B program enables participating organizations to purchase qualifying drugs at substantial discounts (an average of 20% to 40% off of retail pricing). If the transaction includes medical oncologists that currently perform infusion therapy services outside the hospital, the parties should conduct a thorough assessment of 340B drug pricing eligibility to identify options

that maximize the program's benefits. Organizations should at a minimum consider the following questions when evaluating 340B pricing:

- Does the hospital or an affiliated hospital within the system qualify for 340B?
- If the hospital participates in 340B, how large is the practice's chemotherapy program? How many medical oncologists are expected to participate?
- If the hospital participates in 340B, how can it increase its participation through partnerships with community oncologists? And how will the alignment model engage physicians in the program?
- How many qualifying patients (e.g., outpatients, patients with an established relationship with the provider) are expected to participate in the program? What is the expected economic gain?

Ensure proper due diligence

The due diligence process is critical for every transaction and is typically conducted in an iterative fashion, wherein increasingly detailed information is requested from the group. Questions about compensation typically are initiated early in the process. It is critical for the hospital to conduct a thorough assessment of the oncologists' current practice, understanding all revenue streams and expense drivers, before presenting a financial offer to the physicians. This process is important for any specialty acquisition; however, it is particularly important for oncology practices due to the complexities of the practices (e.g., large reliance on ancillary income).

Issues that are commonly identified as a result of the practice assessment include:

- Lack of alignment between compensation and productivity
- Declining compensation and/or productivity over time
- A high level of midlevel services (e.g., infusion management) and/or other services that do not support a work relative value unit (WRVU) compensation model
- High level of outside physician compensation
- Varying compensation plans between employed and shareholder physicians
- Antiquated or poorly maintained capital equipment
- Practices with a large debt load
- Abnormal supply costs relative to production levels

The initial financial review is a critical first step in transaction discussions, but the due diligence process should be ongoing. Due diligence efforts related to implementation planning will begin once a term sheet and/or letter of intent has been finalized. This could include a third-party evaluation of the group's practice (if applicable) and potentially a fair market value (FMV) review of the proposed compensation plan. In addition, there will be a number of other considerations if integrating the group into the hospital (e.g., space planning requirements for provider-based billing compliance). Many of these considerations are outlined in the following sections. To facilitate this process, though, it will be important to share

the implementation timeline with the physicians so they understand the process as well as the rationale behind what may seem like excessive data requests. Involving one or more of the physicians in the implementation will help ensure that the physician group continues to be educated about the key issues being evaluated.

Development of the Organizational Structure

To ensure successful alignment, the hospital and physicians should jointly develop the governance, management, and operating structures for the new arrangement. Clearly defined organizational structures that delineate the reporting relationships among the physicians and hospital executives are a key element to successfully implementing the intended alignment structure.

Group governance

Governance defines the structure under which the integrated entity sets its strategic direction, manages fiduciary responsibilities, and oversees organizational performance. Specifying organizational authority and accountability is a critical element in the development of a group's culture.

Many top oncology programs elect to establish a governance structure that includes joint representation from physicians and hospital leadership. The balance of membership of these groups will vary depending on the ownership structure and the mix of clinical services and array of physician specialties under the aligned structure. Typically, the governance body will provide oversight for the operations, finances, and planning of the oncology group. Depending on the evolution of the service line, group governance may also be integrated with service line governance

structures/functions, as described in Chapter 3. During the planning process, key governance terms should be negotiated and agreed upon, such as:

- Number and selection of governing body members
- Decision-making scope and list of responsibilities
- Role of governing body for the oncology group and (if applicable) within the broader oncology service line
- Voting rights details
- Reserve powers

Management structure

Management of the group should entail experienced administrative leaders to ensure efficient operations but should also incorporate physicians to ensure that they are continuing to monitor operations and are invested in the group's success. In addition, specific management structures should aim to leverage the hospital's employed physician practice capabilities. Defining the management structure in any detail can be a somewhat lengthy process; however, at a minimum, the initial term sheet should outline the following:

- Leadership structure with management relationships noted for key positions
- Job description of key leadership positions
- Appointment of leaders

Operational and clinical integration

It is also important to develop plans that operationally and clinically integrate the group with the service line in order to meet shared objectives. The decisions that will be required in this design phase include definitions of the following areas:

- Operational and clinical integration across subspecialties
- Branding and marketing activities
- Physician recruiting
- Utilization management
- Information exchange, including use of electronic medical records
- Performance reporting
- Staff employment

Developing a Compensation Plan

Developing a physician compensation methodology that aligns physician incentives with hospital oncology programmatic priorities is critical to ensuring that organizational objectives are achieved. Effective compensation methodologies incorporate variables that encourage clinical productivity, quality and coordination of care, financial stability, and other variables identified by hospital leadership. Several models and key considerations for a compensation plan design are outlined in the following pages.

Compensation goals and objectives

In designing a compensation plan, it is important to incorporate provisions that support the hospital's broader service line and organizational objectives. Consequently, the first step when designing a compensation plan should be the development of its desired goals and objectives. Ultimately, the goals that are established at the onset of this planning process are used as the evaluation criteria for alternative arrangements. Figure 5.2 outlines common goals.

FIGURE 5.2

COMMON COMPENSATION GOALS

Philosophical	Clinical	Financial	Other Programmatic
<ul style="list-style-type: none"> • Enhances quality • Aligns compensation with productivity • Is transparent and flexible • Is easy to administer • Is consistent with other hospital payment arrangements 	<ul style="list-style-type: none"> • Improves the patient and physician experience • Promotes coordinated care and clinical integration • Supports subspecialization • Facilitates increased access 	<ul style="list-style-type: none"> • Ensures financial viability • Promotes cost-savings initiatives • Encourages service outreach • Rewards for shared risk 	<ul style="list-style-type: none"> • Supports clinical research efforts • Encourages physician leadership in service line development • Supports other programmatic activity (e.g., citizenship)

Source: ECG Management Consultants, Inc.

Compensation models

The models in the following discussion represent common physician compensation arrangements. Each model has its advantages and disadvantages. In practice, characteristics from these various models are often combined to create incentives to reward desired behaviors and activities.

Model 1—Income guarantee

- **Structure:** A guaranteed salary regardless of practice productivity or finances, set at a predetermined compensation target. It is typically based on an industry-wide percentile and periodically adjusted to reflect changes in productivity.
- **Advantages:** Stabilizes income, clinical model, and culture for physicians; is easy for hospitals to administer.
- **Disadvantages:** Offers little incentive for increased production and the fewest opportunities to align physician and hospital incentives. May result in diminished productivity. Given oncologists' high income levels, may be difficult to provide a full income guarantee from an FMV perspective. Often associated with high losses in the physician practice.
- **Mitigating considerations:** Minimum work thresholds mitigate productivity risk but can be difficult to negotiate.
- **Risk/potential:** High risk for hospitals; low risk for physicians.

Model 2—Base salary plus production bonus

- **Structure:** A guaranteed salary supplemented by a bonus based on WRVUs, new patient visits, and so forth, beyond a set threshold. The bonus may be based on individual productivity, total group productivity in certain situations, or a combination of both.
- **Advantages:** Potentially increases physician income; aligns financial incentives with hospital.
- **Disadvantages:** Offers less income stability for physicians and no incentive for nonclinical physician activities such as administrative contributions to the oncology service line. Oncology ancillary income streams (e.g., infusion) do not necessarily correlate to a WRVU model.
- **Mitigating considerations:** Model could incorporate additional incentives for nonclinical work. The threshold should be set low enough so the production bonus is a significant portion of total compensation.
- **Risk/potential:** Moderate risk/moderate upside potential for physicians depending on where the threshold is set.

Model 3—Base salary plus multiple bonuses

- **Structure:** A guaranteed salary supplemented by bonuses based on factors such as productivity, quality and outcomes, outreach and referral relationships, program development, and patient satisfaction.

- **Advantages:** Flexibly aligns incentives for nonclinical activities. May better align compensation to physicians' historical income levels. Aspects such as standardizing clinical practices may be self-funding.
- **Disadvantages:** Developing service line metrics and valuing nonclinical work can be difficult. May weaken the direct link between compensation and production.
- **Mitigating considerations:** Time studies could be utilized to set payments. WRVUs or other productivity metrics could also be included in the formula. Funding mechanisms for bonus pools need to be determined.
- **Risk/potential:** Moderate risk/moderate-to-high upside potential for physicians.

Model 4—Pure productivity

- **Structure:** No salary guarantee. Physicians are compensated at a fixed rate per WRVU, patient visit, etc., either individually or as a group. The compensation rate may increase for production above certain thresholds.
- **Advantages:** Ensures hospital costs are in line with productivity; is the typical model for professional service agreements, and more prevalent in employment.
- **Disadvantages:** Offers limited income stability for physicians and does not align incentives for physician participation in nonclinical service line work unless these components are added.

- **Mitigating considerations:** Model could incorporate additional incentives for nonclinical work.
- **Risk/potential:** Moderate risk/moderate-to-high upside potential.

Unique considerations

In addition to the general compensation provisions of an agreement, there are unique considerations that emerge in various transaction discussions depending on the dynamics of a particular practice.

Aggregate versus individual payment methodologies

Physician compensation can be based on a pool or allocated individually, depending in particular on the culture of the group. Pooled compensation is often most applicable in professional services agreements (particularly because organizations often receive payment in aggregate and use different allocation methodologies for their individual physician compensation); however, it can also apply to employed arrangements for practices that utilize an equal shares model and believe strongly that a pooled methodology creates a collegial, collaborative group culture. Within groups where there is disparity in production, a model that creates both shared and individual incentives may be more appropriate. Pooled compensation models should have the appropriate controls to manage total compensation at FMV levels.

Infusion suite services

For medical oncology practices that heavily use midlevel providers for the management of infusion services, it is important to consider how productivity and expense will impact their compensation model. In particular, the reporting of physician

productivity through WRVUS will be impacted, as physicians will no longer receive credit for this production if infusion services are transitioned to a hospital-based billing model (because infusion therapy is a designated health service). Depending on the magnitude of this activity, it may be important to structure an arrangement that allows for physicians' continued management of infusion services.

Increasingly, hospitals are opting to create agreements that compensate physicians for management of the infusion suite. Several options are available, depending on the particulars of an arrangement. Many opt for a fixed fee stipend that compensates physicians for services related to infusion suite management. Others incorporate a payment per WRVU premium that reflects incremental compensation associated with management services. An alternate but similar approach to this last methodology is the incorporation of a WRVU credit for clinical services that correlates to infusion management activity. Regardless of the approach, hospitals will need to be cautious in developing their preferred methodology to ensure that payment is in no way tied to hospital-based volume growth.

Service incentives

Hospitals generally recognize that production-driven plans will need to evolve to reflect changing practice patterns and economics, but there is a reluctance to get too far ahead of reimbursement changes. Production-based compensation plans (typically measured in WRVUs) continue to be the favored methodology for hospitals, and they often utilize productivity tiers that disproportionately reward high producers and provide strong incentives at the margin. These plans reflect the current economics of physician payment, which is still based almost entirely on clinical work measures.

Although hospitals typically incorporate some type of performance or quality bonus into their compensation models, the measures are often not based on stretch goals because defining, valuing, tracking, and measuring outcomes can prove difficult. They can provide a huge boon to executing service line strategies, though, and more institutions are starting to incorporate these incentives and make them a larger portion of total compensation (see Figure 5.3 for examples).

FIGURE 5.3
COMMON SERVICE INCENTIVE BONUS STRUCTURES

Category	Examples
Quality	<ul style="list-style-type: none"> • American College of Surgeons quality indicators • American College of Radiology-American Society for Therapeutic Radiology and Oncology accreditation • Reporting of select Physician Quality Reporting System variables • Participation in multidisciplinary clinics • Adherence to established clinical pathways • Standardization of drug regimens and purchasing
Operations	<ul style="list-style-type: none"> • Standardization of clinical processes and/or forms • Improvements in select operational metrics
Patient satisfaction	<ul style="list-style-type: none"> • Survey participation and achievement (e.g., Press Ganey Associates, Inc.) • Availability of appointments
Service line involvement	<ul style="list-style-type: none"> • Participation in tumor boards • Development of continuing medical education programs • Outreach visits to referring physicians • Participation in hospital leadership roles
Financial	<ul style="list-style-type: none"> • Clinical market share • Cost-savings bonuses • Device or supply standardization

Source: ECG Management Consultants, Inc.

Key questions to address when evaluating service incentives include:

- **Picking stretch targets:** Are the metrics attainable? How much effort will be required to reach targets? How should targets be adjusted year over year?
- **Physician control:** Are the metrics related to initiatives under the control of the oncologists? Is there a balance of metrics related to each subspecialty?
- **Areas of emphasis:** How should each metric be weighted (e.g., equally, by importance, by level of difficulty, by time commitment)?
- **Performance measurement:** How easily can the proposed service incentives be tracked and/or measured? Who will be responsible for managing this program?
- **Alignment of goals of hospital and group:** Are the metrics encouraging both the desired group behavior and meeting service line goals?
- **Process-related metrics:** How can we balance metrics aimed at developing processes versus attaining specific measurable levels of achievement?
- **Periodic review:** How often should the planning objectives be reviewed by the hospital and the physicians?

Use of service incentives in physician compensation models is an emerging trend that will continue to grow, particularly in light of ongoing healthcare reform efforts that emphasize patient outcomes and episode-based care.

Surgical oncology call coverage restrictions

With increasing subspecialization of surgical oncologists, many physicians are no longer clinically able or personally willing to cover general surgery call. If the hospital's current emergency department (ED) call coverage arrangement or medical staff bylaws require the physicians to take call, the transaction may require additional funding to compensate surgeons to take general calls.

Other nonclinical duties

Depending on the scope of a particular agreement, other nonclinical duties may need to be taken into account, including but not limited to the following:

- Practice management responsibilities
- Outreach staffing
- Medical directorships and other hospital responsibilities
- Clinical research

Frequently, these types of services are incorporated into the compensation agreement through various performance-related bonuses; some activities (e.g., medical directorships) may reflect separate agreements.

Practice acquisition

If applicable to the arrangement, practice acquisition details should be defined early in the planning process. Hospitals typically purchase a practice's hard assets at FMV. When engaging in the acquisition process, parties should consider the following:

- **Timing:** One of the most common causes for delay in transaction discussions, particularly for large group acquisitions, is the valuation. Consequently, it is helpful to initiate a practice valuation early in the planning process, potentially once a term sheet has been finalized and/or a letter of intent has been signed.
- **Valuation firm selection:** The most successful valuation process usually relies on one third-party valuation firm to conduct the analysis. To ensure trust in the analysis, it is important to have buy-in from each party in valuation firm selection. Some organizations opt to each hire its respective valuation firm to conduct separate analyses; however, this process can often be cumbersome and has the potential to significantly delay the transaction process as the parties reconcile the two reports.
- **Tangible versus intangible assets:** In recent years, most transactions have excluded goodwill and focused solely on tangible/hard assets. Increasingly, some hospitals do value select intangibles (e.g., medical records, workforce in place), but the inclusion of intangibles often only applies to large group acquisitions.
- **Stock versus asset sale:** When acquiring a practice, parties have the option of utilizing two different types of sales—an asset sale and a stock sale. In an asset sale, the hospital is purchasing a defined list of assets and assumes a defined list of liabilities; consequently, the liability of unknown future claims against the corporation is retained by the physicians. This is the most common method used in practice acquisitions. In contrast, under a stock sale, the hospital assumes the liability for all unknown future claims.

Physicians are increasingly requesting the latter option; however, it is important to note that, with the addition of these liabilities, the physician stock is worth less to the hospital than the known quantities of assets and liabilities in an asset sale. In addition, if a stock sale is ultimately considered, there are several steps that should be taken to limit future liabilities. For example, the hospital could retain a portion of sale proceeds or insure against future claims.

- **Equipment leases:** The disposition of the oncology office often depends on whether it is owned by the practice or the office is located in leased space. In addition, oncologists may have engaged in various other lease arrangements that could impact the valuation price. Because the assignment of the various assets to the hospital is usually a condition of closing, any last-minute, unforeseen expenses typically result in incremental costs to the hospital that were previously not budgeted. Consequently, it is important to engage in a due diligence process early on that identifies all relevant agreements and associated costs for the practice.

Key terms

Contract term

Although most oncology agreements are structured for a term of two to three years, an increasing number of organizations are opting for longer contract terms (e.g., five years). Physicians prefer the financial stability associated with a longer contract, and hospitals often consider it part of their broader retention strategy by incorporating vesting provisions into the agreement. For example, some organizations withhold a portion of the physician bonus for a predetermined vesting period;

only after completing the predetermined term would physicians be eligible to receive 100% of their bonus compensation. Due to unforeseen environmental changes, longer contract terms offer some level of additional hospital risk; consequently, it is important to incorporate reset provisions into the compensation plan that ensure some payment flexibility in relation to market changes. Organizations should ensure that any FMV assessment of an alignment arrangement covers the term of the agreement; longer-term arrangements could require periodic FMV updates.

Agreement renewal

Regardless of the contract length, most agreements include a periodic reset every few years to ensure that physician compensation remains commensurate with the FMV. Organizations utilize a variety of industry benchmarks, preferring those with a wide circulation and large sample size.

Some contracts do utilize a fixed payment mechanism in the compensation plan for a predefined period of time (e.g., a five-year compensation per WRVU rate); in these cases, it is still important to incorporate explicit provisions to ensure market-level compensation and FMV compliance. Typically, this involves the utilization of a payment corridor that limits the upside compensation (e.g., 90th percentile or includes events that would trigger an FMV in mid-term) and adjusts for diminished productivity (e.g., a 15% reduction in the compensation rate for a 15% drop in WRVU productivity).

Noncompete agreements

Noncompete provisions generally restrict physicians from competing within a predefined geographic area for one to two years. Restrictions range in complexity

but generally limit physicians' ability to perform specialty services in competing hospitals/facilities within the employer's primary, secondary, and/or tertiary service areas. In situations where the hospital acquires a physician practice, the noncompete may also include provisions that require physicians to pay back a prorated portion of the practice acquisition costs if they terminate the agreement within a predetermined time frame (e.g., two years from the date of employment). However, hospitals should resist the temptation to overreach in writing a noncompete agreement. In many states, if a judge finds that the time or geographic restrictions are unreasonable to protect the hospital's legitimate economic interests, the entire agreement may be void and unenforceable.

Implementation

The key to a long-term successful transaction is effective alignment and integration into a coordinated service line that is capable of achieving the parties' intended goals. It is at the implementation phase immediately following closing that many well-conceived transactions fail. Although often overlooked in the haste of events that typically precede the closing, it is critical that the hospital and physicians carefully plan and execute the implementation steps, which is frequently a two-phase process.

Phase I: Plan development

Following the signing of a term sheet, the parties should develop detailed plans for implementation and integration, including:

- Identifying key stakeholders and knowledge experts from the respective organizations. This typically includes practice administrators and staff from the physician groups.
- Creating an implementation plan (see sidebar for more information).
- Communicating the implementation plan to work groups and seeking input on potential plan changes.

Phase II: Plan implementation

Upon closing, hospital leadership will need to implement this proposed plan by engaging in the following:

- Creating a project manager or project management team to oversee implementation
 - This may encompass several work groups depending on the size and complexity of the implementation
 - In certain circumstances, using independent, external resources to advise or lead implementation through a project management office may better serve the combined entity because it can overcome institutional biases on either side to make decisions that are in its best interests
- Reporting results, progress, and risks to leadership to expedite decision-making and the implementation of risk-mitigation plans
- Continuing to identify cross-functional dependencies

- Monitoring key issues to ensure resolution
- Providing interim management where necessary until permanent candidates can be hired

A well thought out, detailed implementation plan is required to transition responsibilities to the new structure without impairing business performance, employee morale, or patient service. In particular, the hospital needs to take special steps to ensure it makes sound operational decisions and proactively communicates with the physicians. Issues will arise, and maintaining open communication through regularly scheduled leadership meetings and weekly implementation updates is critical to managing the change.

DEVELOPING AN IMPLEMENTATION PLAN

The details of an implementation plan will vary based on the alignment model and the characteristics of the respective organizations. Key features of the implementation plan typically include:

- Identifying, measuring, and monitoring key activities and critical success factors
- Defining target dates for completion and specifying major milestones (e.g., 30-, 60-, and 90-day accomplishments)
- Identifying dependencies among tasks to properly sequence work
- Highlighting difficult integration issues and decisions that warrant board approval
- Identifying milestones and accomplishments
- Assigning accountability of each task to an individual who will be responsible for ensuring that work is completed on time

Key Takeaways

Properly structured, economic oncology alignment arrangements can be mutually beneficial to both parties. The most successful transactions typically apply the following approach:

- Using a rigorous, disciplined, and timely process when negotiating term sheet decisions
 - Initiating key tasks (e.g., practice valuation process) early in transaction discussions to set parameters
 - Understanding market risks and trends before engaging in detailed compensation discussions
- Proactively establishing a shared vision and set of goals that define success
- Determining an appropriate vehicle to meet current and future service line needs
 - Incorporating terms that are tailored to the group by leveraging their strengths and addressing their weaknesses
 - Creating incentives within the compensation plan to align physicians with the hospital's organizational priorities
 - Developing a structure that encourages and allows for strong physician leadership in service line planning and management
- Creating a long-term, financially viable relationship

- Determining an appropriate billing designation to maximize reimbursement opportunities
- Assessing 340B cost-savings opportunities
- Preparing and executing a thorough, detailed implementation plan to ensure effective physician integration upon the transaction's close