Professional Serv

A promising physician-hospital integration model for community

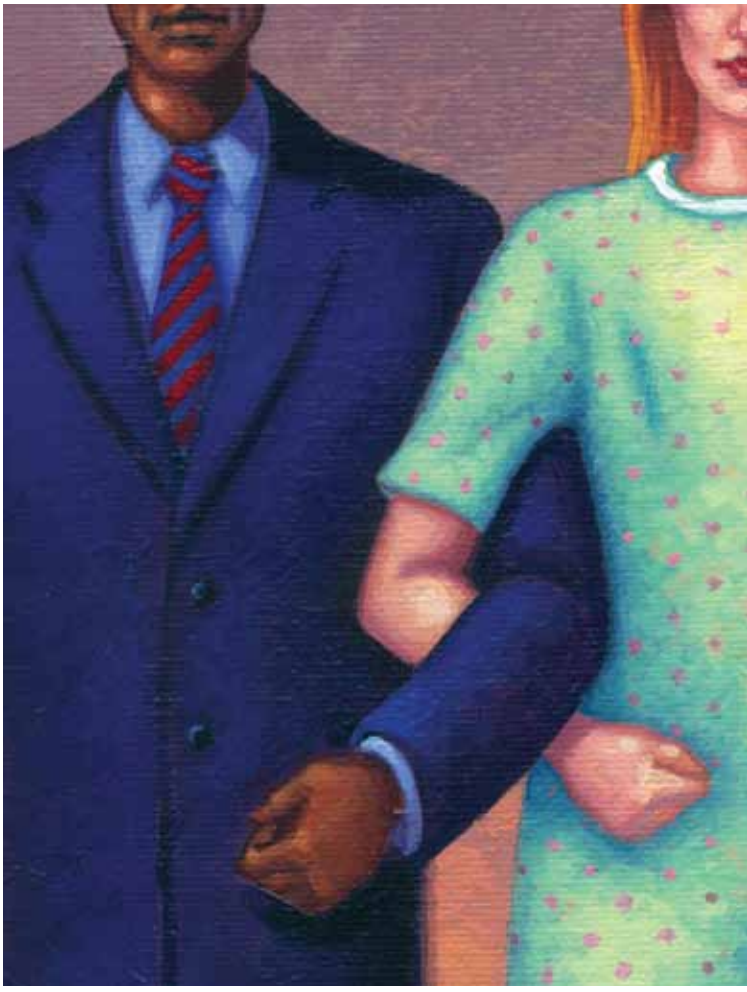
by Chad Schaeffer, FACHE

Over the past several years, medical oncology, like many other physician specialties, has faced a downward reimbursement trend both from Medicare and other third party payers. For oncologists, the reimbursement decline has been even steeper than for some other specialties. According to the Medical Group Management Association's Physician Compensation Survey data, between 2006 and 2008, overall average compensation for a hematology/oncology physician fell 8.3 percent.[1] During the same time period, the compensation level for a single-specialty hematology/oncology physician, in the 90th percentile category, fell 30 percent.[1] Moreover, results of an online benchmarking survey report for 2008 data indicated that medical oncologists' practice expenses increased 15 percent from 2007, while their total collected revenue increased by only 6 percent.[1] These numbers clearly indicate that overall compensation of oncologists has dropped.

Why are Physicians Looking to Hospitals?

Undoubtedly, a medical oncologist's ability to protect his or her reimbursement is essential in maintaining a viable practice. For this reason, many physicians have looked towards hospitals as a potential strategy. From a physician's perspective, hospitals generally represent a beacon of stability in an ever-changing, hostile payer environment. Hospitals tend to have better negotiating power with payers for certain outpatient services compared to average, or even larger-sized, medical oncology groups. But while increasing revenue might be a strong alignment motivator, hospitals and physicians can realize a number of other tangible benefits by working together, including:

- ***Reducing costs by eliminating duplicative services.*** In most cases, community oncologists provide infusion services in their own private offices. Hospitals often also provide an outpatient infusion service. Working in concert eliminates the need for both programs to carry the same direct expenses and overhead costs. Instead, the costs of the space, labor, and supplies can be shared by both the practice and the hospital.
- ***Providing a more integrated care delivery model.*** Often, oncologists in the community setting send uninsured and underinsured patients to the hospital setting for treatment, keeping better paying patients in their practice for their anti-cancer treatment. By working together, oncologists and hospitals can provide all outpatient infusion services at a single site for patients in their community. No longer will insurance dictate where patients go for treatment, how long they have to wait, or the level of physician supervision that is available. By working in partnership, all of the quality standards from the physician's practice and the hospital can be melded together to provide a single care pathway for all patients.
- ***Accessing the 340B drug pricing program.*** While pri-



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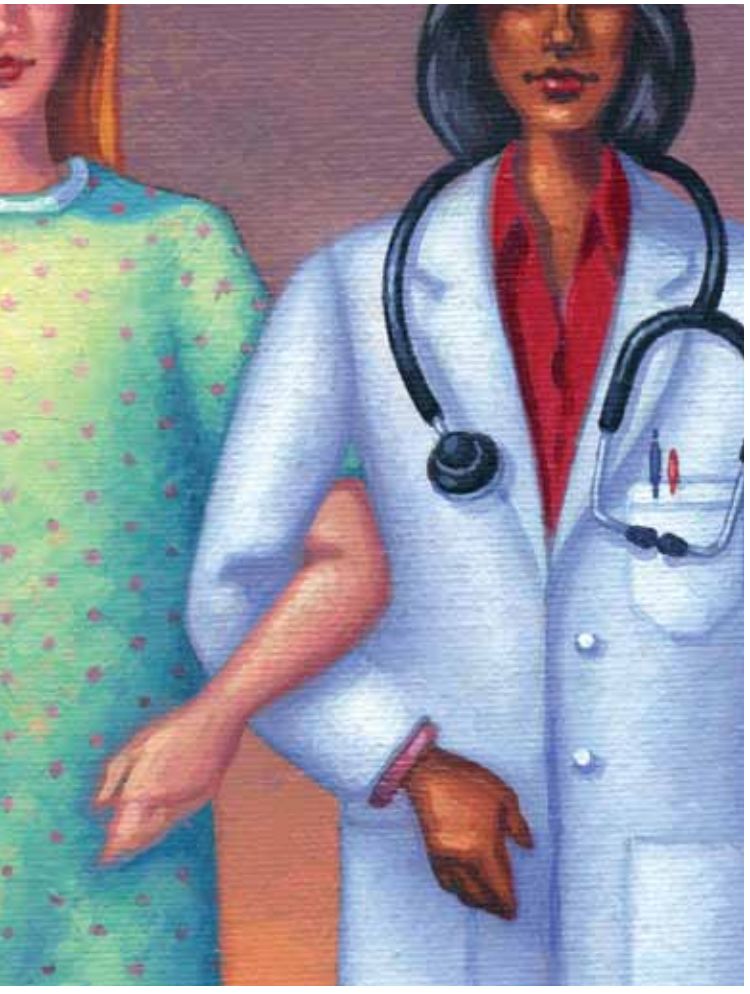


ILLUSTRATION/ERIC WESTBROOK

vate practice physicians cannot legally benefit financially from a hospital's 340B drug pricing program, the overall community can benefit. A hospital's ability to offer a premier medical oncology service in a community that has a large percentage of underinsured patients is often only made possible through participation in the 340B drug pricing program.

What are the Options?

Physicians and hospitals have explored a number of models for working together. Perhaps the simplest, structurally, is an employment arrangement. However, many private practice physicians are still reluctant to become hospital-employed physicians. Generally, oncologists are uncomfortable with the perceived (and potentially real) loss of overall control of their practice. For this reason, many oncologists have opted for hospital-physician alignment models that do not involve employment. In recent years, medical oncologists and hospitals have explored a number of non-employment organizational alignment models, including CT, PET/CT, and radiation therapy joint ventures; medical oncology "under arrangements;" and service line co-management agreements.

But Wait, More Regulatory Pressures: Now What?

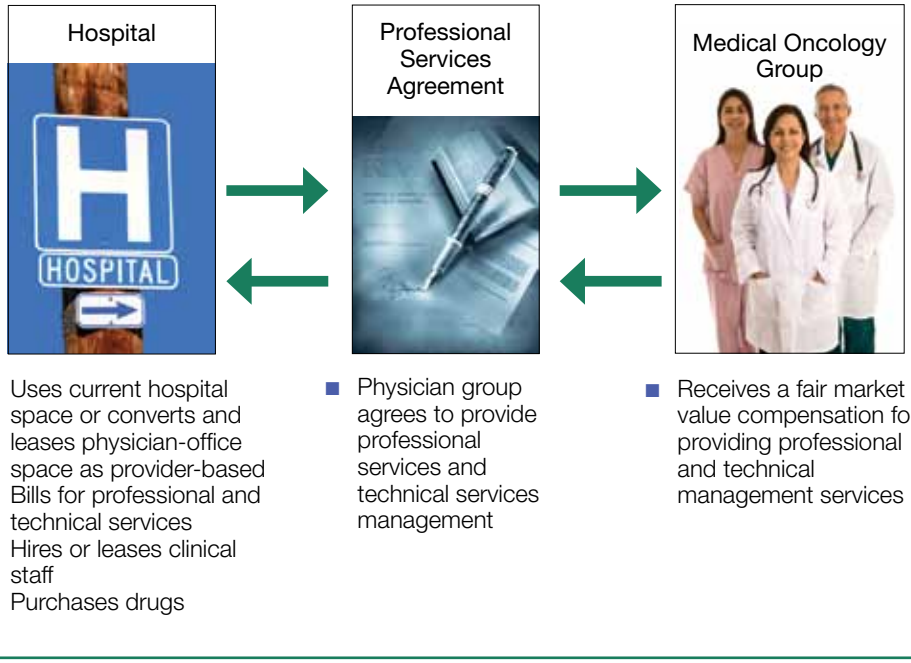
Then on Oct. 1, 2009, everything changed. With the full implementation of the final Stark II, Phase III Laws (also known as "Stark III"), many of the physician-hospital collaborative models widely used in the last decade were no longer regulatory compliant. Hospitals and physicians could no longer provide oncology services through partnerships using "under arrangements" or equipment-based joint ventures through "per-click" leasing arrangements. These models let many hospitals provide and bill for oncology services, while allowing physician practices to participate in the risks and rewards of the businesses. Stark III laws have now made these specific models illegal. In many instances, the new rules called for previous alignment strategies to be restructured or unwound. Additionally, many physicians and hospitals who were exploring a partnership strategy ceased discussions amidst the increasingly regulated milieu. Clearly, a new paradigm in oncologist-hospital alignment strategies was sorely needed.

PSAs—A Promising Physician-Hospital Integration Model

Professional services agreements (PSAs) are certainly not new and have been used by hospitals for a variety of services. PSAs provide a viable alternative to physician employment by establishing an independent contractor type of relationship between the hospital and physician, whereby the physician can be paid compensation to provide physicians' services that are beneficial to the hospital. For instance, a large hospital system that wishes to create an oncology center of excellence might approach a large group of medical oncolo-

gists and purchase some of their services through a PSA (see the case study on page 24). The oncology group would be paid a fair market value rate for several full-time equivalent medical oncologists, and, in turn, the hospital would receive the assistance of their professional services and medical oversight of the chemotherapy and infusion services.

Figure 1a. Framework for Professional Services Agreement



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The Oncologist's Perspective

The PSA model offers a few distinct advantages for medical oncologists in private practice.

First, the oncology group remains a private practice. The oncologists are not employed by the hospital, so they can retain their independence. Depending on the terms of the PSA, the oncologists can often keep other practice locations and maintain desired and/or appropriate staffing levels.

A PSA can also reduce the oncology practice's overhead and cost structure. The hospital will either lease or directly employ the clinical staff providing the chemotherapy, purchase the chemotherapy drugs, and pay for all or most of the space required, thus reducing the practices' overhead and risk.

In addition, the oncology practice's billing for services rendered is simplified, shifting away from many payers to a single payer for chemotherapy services rendered. Under the PSA, the hospital takes over the billing for the chemotherapy services and pays the oncologists a fair market value fee for medical oversight of these services. Under some PSAs, the hospital also bills for the professional services. In this instance, the oncology practice will then be reimbursed for both the professional services provided and the technical services oversight.

The Hospital's Perspective

A hospital that wants to establish an oncology center of excellence must have physician participation to realize its goals. When a hospital does not employ physicians in a particular area that it wishes to develop, and when physician employment is simply not a viable option, a PSA with a vibrant medical group is an excellent alternative. If desired, a separate medical director role, agreed upon by both parties, can be layered into the PSA.

Another benefit to hospitals is increased physician participation in terms of clinical oversight. Currently, most hospital-based infusion services are not directly supervised by private practice physicians since they are usually in their offices or rounding in the hospital. Private-practice physicians are rarely physically located in the hospital outpatient infusion area. Instead, hospitals use either a physician extender or contract with another physician to provide the required level of clinical supervision. Most hospital administrators would agree that increased physician supervision is an optimal cancer care delivery model.

A PSA model will support the hospital's development of a full-service oncology infusion program. When physicians are providing the majority of the infusion services in their private practices, the hospital is usually left with a fledgling service—not large enough to build a superior staffing pattern with amenities for patients, but too small to eliminate labor costs or other overhead. By entering into a PSA with a group of oncologists, the hospital's infusion program will become a significant business. With a larger program, the hospital has the opportunity to provide an effective infrastructure to support a competitive quality program.

The PSA model can also increase accruals in a hospital-based clinical trials program. When the majority of the medical oncology services are provided in the physician-office setting, hospital-based infusion programs often have relatively fragmented clinical trials programs. The physicians' accrual rate might be excellent in their own offices, but there is sometimes a lower accrual rate to hospital-based clinical trials. Often the hospital's open clinical trials are overlooked by private practice physicians because the physicians are enrolling patients in their own trials—usually industry or pharmaceutical trials—in the office setting. Under the PSA model, medical oncologists can be encouraged (and assisted by hospital staff) to help build an integrated clinical trials program that screens all patients for clinical trials.

Another advantage: PSAs offer hospitals the potential to develop a new revenue stream. Hospitals that implement a new or expanded outpatient chemotherapy infusion program may find a new source of revenue within the oncology service line. Depending on the strength of the hospital's

Figure 1b. Framework for Oncology Services Agreement

- Uses current hospital space or converts and leases physician-office space as provider-based
- Bills for technical services only
- Hires or leases clinical technical staff
- Purchases drugs

- Physician group agrees to provide technical services management oversight

- Bills for professional E&M services
- Receives a fair market value compensation for providing physician oversight of chemotherapy and infusion services

payer contracts, the new service line may garner a healthy revenue stream and a new source of bottom-line contribution for these new or expanded services. Additionally, the hospital can expect some "downstream" revenue as the oncology service will depend on a number of other ancillary services, such as imaging and clinical lab diagnostics.

Finally, PSAs offer cost-savings potential. As mentioned earlier, some hospitals may be able to purchase drugs at a lower price than the physician practice. The hospital's group purchasing vendor may hold better rates for certain key drugs. If the hospital system is eligible to participate in the 340B drug pricing program, a significant reduction in drug costs may be realized. All of these savings can help ensure that patients have access to the best care, regardless of their ability to pay. Such savings can be reinvested in cancer program services that are needed in the community, but are often not reimbursed, such as social worker services, patient navigation services, and survivorship programs.

Step 1—Establish Goals and Desired Outcomes

Entering into a professional services agreement requires several key steps for both the hospital and the medical oncologists. An important first step is to identify the mutual goals or desired outcome of the project. Potential goals for the PSA might include:

- Improving the overall quality of all outpatient infusion services
- Decreasing duplication of services within the community
- Providing seamless integration of hospital-based and physician-office medical records, including implementing full use of EHR for oncology patients
- Engaging oncology physician partners to assist with the hospital's oncology service line development
- Improving accessibility for indigent patients by accessing better drug pricing programs, such as 340B
- Increasing clinical trial enrollment
- Providing needed professional medical oncology services within the community.

Each participant should think about how the PSA model will help achieve the goals established. When valuation and legal firms evaluate models between hospitals and physicians, it is important that the goals of the project are clear and that the partnership is motivated by more than purely financial incentives.

Once the goals and desired outcomes have been agreed on, the parties may want to identify a law firm to help with the project. It is wise to select a legal firm that has prior experience with developing physician PSAs. The attorney should be selected early in the process. Typically, the attorney will want to play a more active role after each party has determined the desired goals of the project. The law firm can help guide the project during subsequent steps, such as determining the exact PSA model, seeking the fair market value compensation opinion, and reviewing the expected financials.

Step 2—Determine Basic Terms of the PSA Model and Expected Impact

As depicted in Figure 1a, a PSA between a hospital and an oncology group typically involves the hospital purchasing both professional and technical oversight services for the outpatient infusion and chemotherapy service. In this model, the physicians are paid a fair market value for their services (to include their compensation) by the hospital. Thus, the hospital is billing both the professional and technical services. This is the most common PSA model and achieves the greatest integration of oncology outpatient services since the patients have only one provider generating bills for service.

A second option (see Figure 1b) is an Oncology Services Agreement (OSA). This differs from a PSA in that the medical oncology group only provides to the hospital technical services and management oversight for chemotherapy and infusion services. In the OSA model, the oncology group continues to bill for professional medical oncology services (e.g., new patient visits, established patient visits, and procedures). The hospital pays a fair market compensation amount to the medical oncology group. This amount will be less than under a PSA because the oncology group is not providing the hospital with the same level of services. The hospital will bill only for the patient's technical services (e.g., chemotherapy

Professional Services Agreement:
A Sample Case Study

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Author's Note: *While this is only a sample case study, it is based, in large part, on an actual PSA transaction between a hospital and private physician oncology group developed in 2009. The names of the hospital and practice used in this case study are fictitious.*

The Players

Blue View Regional Health System, a large 500-bed teaching hospital in the Northeast, was interested in developing an Oncology Center of Excellence. One large private practice oncology group, Northeast Oncology Group (NOG), provided outpatient medical oncology services in multiple private offices throughout the city. Blue View had a full-service radiation oncology program, its own outpatient infusion service, and a strong breast program with breast surgeons, dedicated breast radiologists, and a new diagnostic breast center.

To build on its excellent reputation for breast care in the region, Blue View decided to develop a new regional cancer center. The new cancer center would house all of Blue View's outpatient cancer care services (radiation oncology and medical oncology) in a new facility next to the recently opened breast center. With this vision in mind, Blue View approached NOG to discuss the concept of entering into a Professional Services Agreement (PSA).

NOG agreed with the PSA terms and assigned six full-time medical oncologists to be located in the new Blue View Regional Cancer Center. NOG also agreed to close two of its offices and collapse them into the new cancer center. Blue View and NOG created an implementation committee that looked at the operations of the existing hospital-based infusion service and the private offices that would be moving into the new cancer center. The committee made decisions regarding the optimal staffing pattern, business operations, setting quality guidelines and measures, governance, and accountability. Operations began within 120 days.

The Outcome

NOG received a fair market value payment—including physician compensation—for each of the six medical oncologists and "gave up" many of the costs of providing the clinical operations since they no longer carried these costs. NOG was also able to save on rent and overhead by closing two office locations. The hospital invested in an electronic health record (EHR) that was needed to link the program with radiation oncology and the hospital's systems. The net result was positive from both an income perspective and from a strategic perspective since NOG has further solidified its role in the market.

Partnering with NOG, Blue View successfully opened the regional cancer center in town, creating a superior patient environment and a one-stop shop approach to cancer treatment. Today, the vast majority of patients stay for radiation therapy and subsequent supportive care programs. The hospital became eligible to participate in the 340B drug program and began to see a positive margin on the new medical oncology service line. This success allowed the hospital to re-invest in all aspects of the cancer program, leading to a more developed Oncology Center of Excellence.

administration, drugs, nursing, and facility fees). The OSA model is less integrated than a full PSA as patients will have two providers for their outpatient chemotherapy service.

Selection of the PSA or the OSA will depend on the hospital's and physicians' motivations and goals established at the outset of the partnership discussions (Step 1).

Another basic component of the agreement is the space to provide services. Under a PSA model, the space must be converted to hospital-based space and meet the requirements of a hospital-based department or service. Under an OSA, the portion of the space dedicated to professional services can either be set-up as a physician-based space or hospital-based space. The differences between the two will have an impact on both professional reimbursement and practice overhead. The oncology group will need to decide which option best meets the practice's needs.

Once the model has been selected, the hospital and the physician group should examine the model's impact on overall operations and strategy. Think through and carefully answer such questions as:

- How will the model affect the existing patient flow and day-to-day operations?
- Where will patients be seen?
- Will the new model and/or location make it easier for patients to be seen in a more timely manner?
- Are there efficiencies to be gained?
- Is there overhead that can be eliminated?
- Will the new model contribute to patient convenience?
- Will it affect parking?
- How will the model affect nursing and clerical staff?
- How will it impact the oncologists' and hospital's relationships with referring physicians and other medical staff?
- How are competitors likely to respond?
- How will the partnership impact market share?

The answers to these strategic and operational questions are important, and will help both the hospital and the physician group prepare for implementation activities.

Step 3—Obtain a Fair Market Value Opinion from a Third Party

The next important step is obtaining an opinion letter from an independent third party that includes a recommendation of the fair market value payment from the hospital to the physician group for the services rendered. Fair market value is defined as "the price, expressed in terms of cash equivalents, at which [the physicians' services] would change hands between a hypothetical willing and able buyer and hypothetical willing and able seller, acting at arms length in an open and unrestricted market, when neither is under compulsion to buy or sell and when both parties have reasonable knowledge of the relevant facts."[2] For the fair market value to stand-up to regulatory scrutiny, it is very important that an independent firm render this opinion.

Steve Rice, executive vice president with Integrated Health Strategies, a firm specializing in physician compensation valuations, offers this clarification: "The valuation process for determining the fair market value is focused on what is reasonable compensation for the physicians' services." Mr. Rice points out that for valuation experts to do this correctly, they must fully understand the market forces of each particular situation. Thus, the valuation firm will consider the proposed roles of the hospital and the physician practice; assess the operating costs that will be paid by the physician group and/or the hospital; and evaluate the relative risk of each participant.

The valuation process typically takes into account the reimbursement climate, payer trends, and physician compensation, from both a national and a local perspective. As available, valuators will compare the proposed PSA transaction with similar transactions completed between hospitals and physician groups in other locations across the country. Given all available information, the fair market value opinion is typically provided within several weeks. Mr. Rice generally reminds his clients that the valuation process should not be rushed since it is a critical step in developing a successful PSA transaction.

Step 4—Prepare Financial Models

Once the parties have the firm market value opinion for the proposed services to be provided by the physicians under the PSA, the next step is to complete financial modeling, identifying the expected financial performance for the medical oncology group and the hospital. The financial models need to consider the proposed payment terms under the PSA and the new costs that will be incurred by the hospital in order to offer the infusion services as hospital-based.

To meet the requirements of hospital-based status, hospital must ensure that the new service:[3]

- Falls under the same license as the hospital
- Is fully integrated with the clinical services of the hospital (hospital privileges, relationship to medical director, medical staff committees, medical records, monitoring and oversight, accessibility to other inpatient and outpatient services)
- Is fully integrated with financial operations
- Is presented to the public as a part of the hospital.

If the service will be provided off of the hospital's main campus, additional requirements must be met. Typically, the hospital-based rules prohibit locations that are more than 35 miles away from the hospital's main campus. In some instances, compliance with the Centers for Medicare & Medicaid Services (CMS) hospital-based rules could increase the cost of doing business, and the financial modeling needs to account for these differences.

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Beyond CMS requirements, additional costs may be incurred when switching the chemotherapy from physician-based to hospital-based. In some cases, the hospital might require a different staffing pattern or might have different credentialing requirements for some of the technical staff. For example, a pharmacist might be required to mix the chemotherapy drugs or to directly supervise pharmacy technicians whereas in the physician-office setting, chemotherapy nurses mixed the anticancer drugs. The financial model must include any such additional costs.

From a revenue perspective, financial modeling must take into account the difference in expected reimbursement if the service moves from practice-based to hospital-based, as many hospital's payer contracts differ from practices' contracts.

Step 5—Seek Legal Assistance to Prepare the Written PSA

When the financial modeling is complete, the final step is preparing the written agreements for execution by both parties. While developing the actual written PSA is a final step, as mentioned above, an attorney should actually be selected early on and be involved throughout much of the process.

Going Forward

Given the financial pressures faced by many hospitals and physicians today, an increased interest in physician-hospital alignment has emerged as a trend for community cancer centers. Professional service agreements may prove to be a viable option over the more regulated and scrutinized joint ventures of the previous decade. Given the real potential for physician-hospital clinical integration, decreased overhead and operating expenses, improved revenue streams, and enhanced patient care management, we can expect that PSAs will be an area of focus for the coming years.

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[3]Centers for Medicare & Medicaid Services. CMS Manual, 42 Code of Federal Regulations, (CFR) 413.6.