



Transitions & Transactions

The “Why” and “How” of Integrated Cancer Services

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In Brief

Cancer care providers, both in the hospital and practice setting, are in the midst of uncharted and stormy waters. Few would disagree about the need for the strategic alignment of hospitals, physicians, and related cancer services. Although most understand that the next five years will see industry-wide transitions to new cancer care delivery models, there is much debate on how best to achieve strategic, economic, and operational integration across multiple providers and sites of care. And since each market has different characteristics, one size does *not* fit all. The good news is that many options are available. The caveat: an effective integration strategy may entail changes in the structure and culture of the oncology community. This article discusses options for closer alignment between physicians and hospitals and describes the required steps for a successful transaction.

Over the past few years, *consolidation*, *integration*, and *clinical* coordination have achieved buzzword status. While undoubtedly overused and often ill-defined, these concepts are central to the delivery of cancer care in the next decade. As a starting point for discussion, here are definitions for these key terms:

- **Consolidation**—Bringing cancer physicians together under a single tax ID number.
- **Integration**—A hospital or health system employing providers and buying their practices.
- **Clinical Coordination**—Management of patient care across conditions, providers, settings, and time with a focus on care that is effective, efficient, and patient-centered. Often, clinical coordination is organized and expressed through a cancer service line.

Developing a cancer service line strategy and a model to create the right physician and hospital alignment requires an understanding of where oncology is headed in the next five years and beyond. New requirements for clinical integration between and among hospitals and physicians are very likely to include:

- A high degree of interdependence between providers and hospitals.
- Full-panel oncology providers with required in-network referrals.
- Integrated information technology (EHRs) and robust reporting capabilities.
- Basic competence in population health management.
- Defined clinical protocols and pathways across a broad spectrum of diagnoses and procedures.
- Sophisticated revenue distribution and compensation methodologies to align incentives.

- Noncompliance sanctions for both physicians and institutions.

While it takes years to reach fully developed coordinated care, hospitals should begin by considering potential partners and possible relationships in terms of how each choice promotes or prevents achievement of meaningful care coordination care across the cancer service line.

Why Oncology Providers Need Each Other

In the near term, providers must face the difficult question—*Why does anything need to change?* For some physician practices, “staying the course” may be an attractive option; however, even these groups need to understand that catalysts for change are many and varied. For hospitals and oncology practices, drivers of change include:

- A large and growing demand for services, making oncology a priority.
- Dominant volumes in ambulatory services, pointing to physician practice acquisitions as a logical expansion strategy.
- Payment reform initiatives, including value-based and bundled payments, as well as significant incentives to provide integrated oncology services.
- The need to attract and retain a dedicated group of oncology providers or risk losing them to a rival hospital or system.
- Major opportunities for hospitals to increase cancer service line reimbursement and profitability.
- An evolving competitive landscape that demands greater clinical coordination among the various oncology service providers.
- Increased competition for lucrative ambulatory services,



Table 1. Hematology and Oncology Collections for Professional Charges, 2008 to 2010

YEAR	MEDIAN	PERCENTAGE CHANGE FROM PREVIOUS YEAR
2010	\$486,293	-9.0%
2009	\$534,573	-22.8%
2008	\$692,879	N/A

Source: 2008 to 2010 MGMA *Physician Compensation and Production Surveys*, Table 5.6, Physician Collections for Professional Charges (TC/NPP Excluded) by Hospital Ownership—Hematology/Oncology.

Table 2. Hematology and Oncology Physician Compensation, 2008 to 2010

HOSPITAL-OWNED			NOT HOSPITAL-OWNED	
YEAR	MEDIAN	PERCENTAGE CHANGE FROM PREVIOUS YEAR	MEDIAN	PERCENTAGE CHANGE FROM PREVIOUS YEAR
2010	\$375,000	18.1%	\$404,412	0.8%
2009	\$317,543	-6.3%	\$401,125	2.5%
2008	\$338,854	N/A		

Source: 2008 to 2010 MGMA *Physician Compensation and Production Surveys*, Table 1.6, Physician Compensation (More Than 1 Year in Specialty) by Hospital Ownership – Hematology/Oncology.

such as imaging and radiation oncology.

- Growing demands for cost containment and value-based healthcare.

For oncologists, in addition to the concern for improving quality of care, interest in consolidation or integration is most often centered on a combination of compensation and lifestyle considerations. Simply put—*What do I need to do to maximize my income over time while maintaining an acceptable work schedule?*

Consider the data points in Tables 1 and 2 above. On the revenue side, over the past several years, reductions in Medicare payments for both professional services and infusion drugs have taken a big bite out of medical oncologists' revenue. Between 2008 and 2010, the median oncologist collections for professional charges declined 30 percent. In response to this loss of revenue, most practices have increased efficiency in efforts to avoid declining income. While independent oncologists have managed to eke out small increases in pay over the past two years, compensation for hospital-employed medical oncologists increased by more than 12 percent. (Note that although median compensation levels remain slightly lower for employed oncologists, the gap is narrowing quickly.)

As drug reimbursement and professional fees continue to experience downward pressure from Medicare, oncologists will find it increasingly difficult to maintain historic income levels. Hospitals are often able (and willing) to pay physicians more because of the practice's value to the cancer service line and a more favorable reimbursement model. When hospitals are able to provide attractive compensation and stability, oncologists in private practice view the integration option quite favorably and often seek out employment offers.

The message is that most hospitals and oncologists have very good reasons for considering integration. And the pressure for economic alignment is likely to remain high for the foreseeable future. While many organizations have chosen to adopt a "watchful waiting" approach to integration, this stance offers a number of risks that must be carefully evaluated, including:

- In a rapidly consolidating market, your competitors may be busy forming an integrated cancer program or service line that could significantly alter the available options in a year or two.
- While the provision of healthcare services is highly localized, the competition for providers is occurring on a national scale. Programs that seek to preserve the status quo



may quickly find themselves at a competitive disadvantage in recruiting and retaining providers.

- Responding to new payment models (e.g., ACOs, bundled payments) will require a high degree of integration and coordination. Organizations that focus on integration and coordination *prior to* seeking to participate in new payment models will have a competitive advantage.
- Oncologists must carefully consider the timing of integration with the hospital. The economic terms of integration are often a function of the practice's current performance and industry-wide trends. It is advantageous for groups to integrate *before* their financial performance declines further.

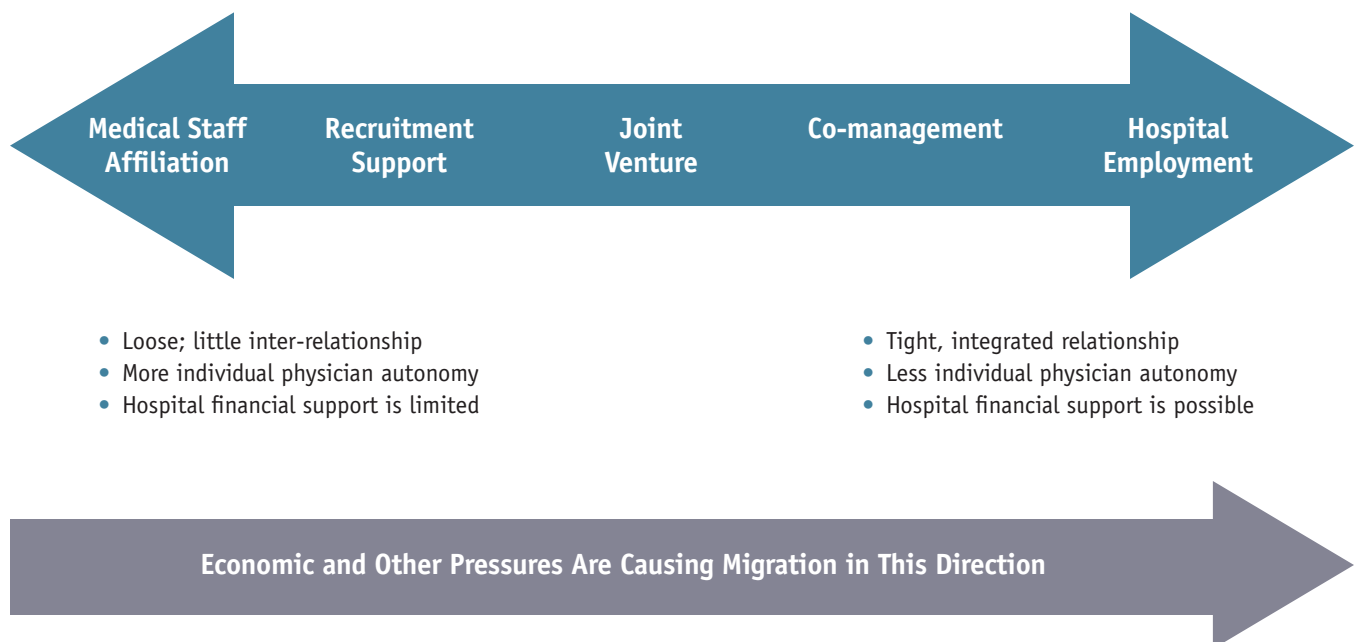
With this understanding of why hospitals and physicians are logical partners in an integrated cancer care line in mind, the next question is how to achieve such a partnership. The basic models for hospitals and oncologists to work together are illustrated in Figure 1 below. The traditional models, including medical staff affiliation, recruitment support, and joint ventures, may be useful in some instances, but do little to address the issues of clinical and economic integration. Models that include the elements of true integration are discussed below.

Co-management Arrangements

Under a co-management arrangement, oncologists and the hospital form a joint venture management company for the purpose of providing management services for the cancer service line or specific elements of the service line, such as the infusion center. The management company works with hospital administration to lead the service line and implement strategies. The management company, through its designated physician leaders, provides administrative, medical director, and quality improvement services, as negotiated by the management company. Ownership of the management company and distributions are based on the capital contributed to the venture. Figure 2, page 36, shows a sample co-management model structure.

The major benefit of co-management is that physicians become partners with the hospital in driving programmatic development. Also, in this structure, physician managers are in a strong position to enhance coordination of care. A great deal of control is ceded to the management company, giving it the ability to make significant positive changes. Financially, physicians can benefit if they are able to achieve performance goals set by the management company. Physicians often find this model attractive because they are able to remain independent of the hospital; however, co-management relationships

Figure 1. Range of Affiliation Models

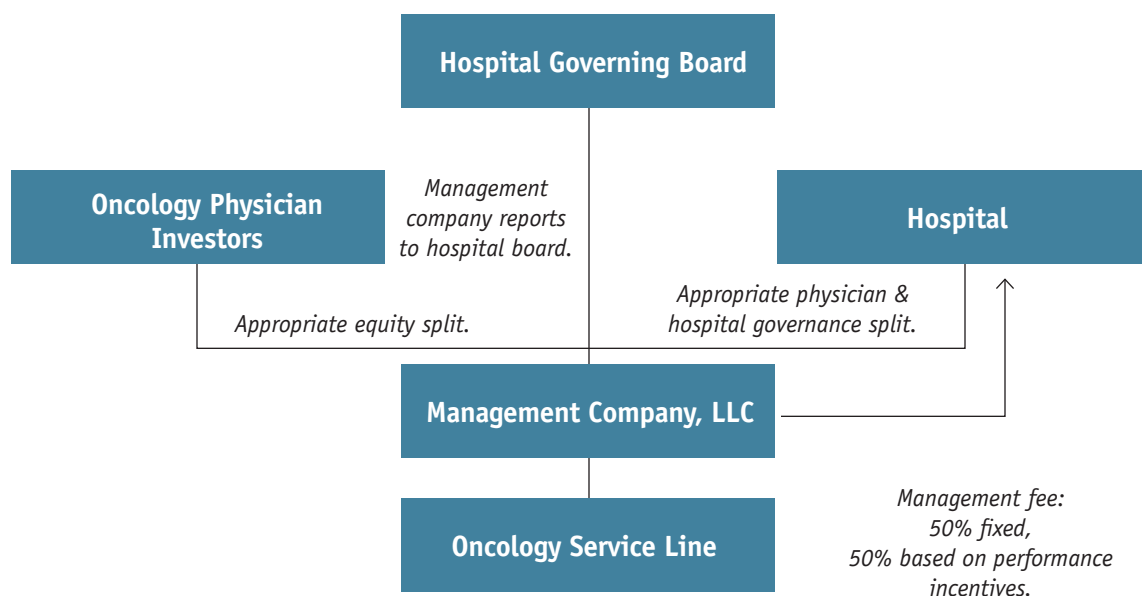


- Loose; little inter-relationship
- More individual physician autonomy
- Hospital financial support is limited

- Tight, integrated relationship
- Less individual physician autonomy
- Hospital financial support is possible

Economic and Other Pressures Are Causing Migration in This Direction

Figure 2. Example of a Co-management Model Structure



frequently involve diverse physician interests, which complicate reaching an agreement.

Employment Structures

Employment structures offer varying degrees of integration both among the oncologists and between the hospital and the physicians.

One basic employment structure is *service line employment*. In this model, oncologists are employed through the service line or cancer center of the hospital. Typically, these models include distinct employment arrangements, dedicated oversight, and decentralized support services from other physician practices employed by the hospital or health system. Commonly, governance functions for these groups are integrated with service line governance.

Another model is an *employed multispecialty group* structure. In this model, the oncologists join the physician organization of the hospital or health system. The model is characterized by a single, integrated structure with unified governance, as well as common policies and support infrastructure for all physicians.

Professional Services Agreements

PSAs are an alternative to physician employment. In the PSA model, a group(s) of oncologists is linked to a separately

incorporated hospital through a professional services agreement. The hospital generally employs all staff, provides all support services, and negotiates managed care contracts. The basic arrangement is depicted in Figure 3, page 37.

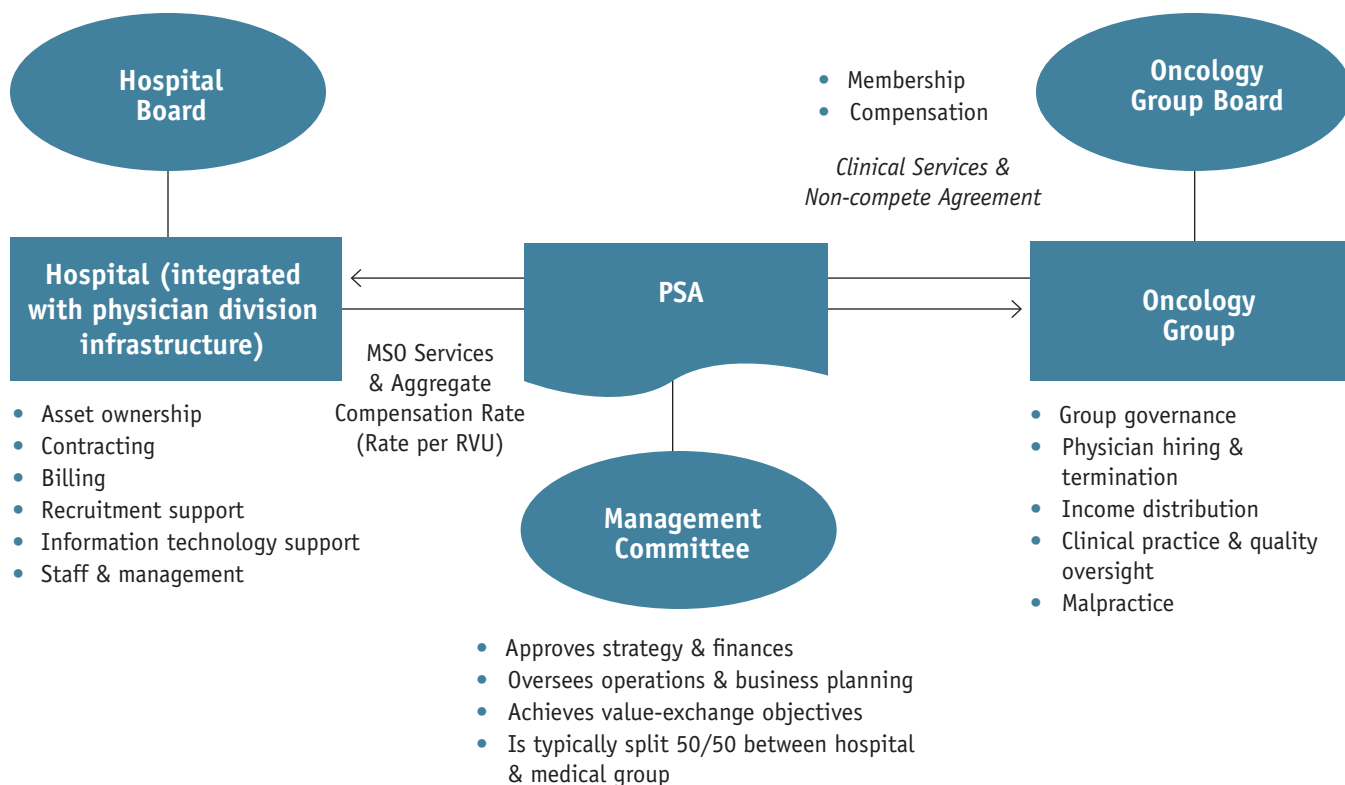
Professional services agreements are attractive because they create strong, coordinated relationships, yet allow physicians to remain relatively independent. PSAs are also flexible in that the services covered and the terms involved can be tailored to fit the circumstances. Often hospitals and health systems choose this type of arrangement because the organization is willing to invest in a tightly integrated oncology group, but faces physician resistance to employment. To ensure successful integration, the PSA should be tailored to not only create aligned incentives, but also to promote physician leadership through joint service line management and/or governance.

Service Line or Medical Group Employment

Often, acquired practices are fearful that they will be controlled or have their control diluted by other physicians, regardless of specialty. In other words, physician resistance is likely to be high if there is a perception that oncologists are being forced into a larger physician structure.

While integrated physician organizations have many benefits for hospitals and health systems in terms of standardizing the governance and operations of the physician practice,

Figure 3. Sample PSA Structure



integrated physician organizations may or may not be the appropriate solution for employed oncologists. Determine the appropriate structure for physician employment based on a careful assessment of the following variables for the employed physician organization versus the cancer service line:

- Size and sophistication
- Strategic direction
- Ability to integrate oncologists with other cancer care providers and/or referring physicians
- Other organizational demands and political realities.

While employing physicians through the service line will likely create certain inefficiencies, many organizations have found that this employment approach: 1) provides greater flexibility in responding to the unique needs of oncologists and 2) fosters the development of the service line through tighter integration and alignment with the oncologists.

Infusion Services

Careful planning is needed to decide if infusion services should be under the umbrella of the physicians or the hospital. Given typical hospital payer and purchasing contracts—including potential access to the 340B Drug Pricing Program—it is usually advantageous to transition infusion services to provider-based (i.e., hospital-based). The associated changes to policies,

and operations within the oncology practice must be clearly communicated to the physicians. Significant changes are required, including:

- ✓ To meet purchasing and payer requirements, the costs associated with infusion and pharmacy must be tied directly to the hospital’s cost report and tax ID number. Carefully consider the operational and financial structures that need to be implemented to support these requirements.
- ✓ Most notably, pharmacy and infusion suite operations must comply with hospital outpatient regulations. The feasibility process should include a review of current workflow(s) to evaluate the implications of converting services to hospital-based billing.
- ✓ With a conversion to hospital-based billing, the revenue cycle for an outpatient department must now be run through the hospital. For example, registration and billing systems must be implemented to bill infusion administration and drug charges on a UB-04 instead of a CMS-1500.

Physician compensation is more complex in a provider-based environment where infusion therapy services are rendered by the hospital and not the physicians. When infusion services are under the umbrella of the hospital, chemotherapy is recognized as a designated health service under the Stark law and physicians cannot receive wRVU (work relative value



units) credits for chemotherapy administration. This means that even though physicians still provide supervision for chemotherapy administration, they do not earn wRVUs for this activity. To account for the virtual loss of production, organizations are increasingly adopting a model that provides a fixed base salary or wRVU credit for the historical income generated from the infusion administration services. For a more detailed description of compensation models for employed physicians, refer to “Physician Compensation: Designing the ‘Best-Fit’ Plan” in the March/April 2012 *Oncology Issues*.

Practice Management

Hospitals are unfamiliar with operating medical oncology practices, and careful planning should be done before transitioning an oncology practice into existing hospital systems. Hospitals that take into account and fully understand oncology-specific revenue cycle practices, EHR systems, and infusion treatment protocols can often develop interface solutions rather than replace physician office systems with hospital systems. A detailed discussion of practice management of employed physician practices is beyond the scope of this article. For additional information, go to the Meeting OnDemand broadcast of “Financial Optimization of Employed Physician Practices” from the ACCC 2012 Annual National Meeting. The broadcast is available at: <http://accc-cancer.org/meetings/meetings-AM2012-highlights.asp>.

Key Transaction Documents

It is important to understand the key documents that will be part of any integration initiative. These documents should not be viewed as something for attorneys and financial experts to work out. Because they summarize all of the critical elements of the future relationship, it is critical that both senior hospital administrators and physician leaders are fully involved in the development of these documents. The following is a summary of the documents required to complete each step. (Note: the traditional caveat that we, the authors, are healthcare consultants, not attorneys, applies. Hospitals and physicians will need to coordinate closely with a legal adviser experienced in group acquisitions and mergers.)

Confidentiality Agreement & Nondisclosure Agreement

The parties agree not to disclose information that may be acquired during the discussion and negotiation process, and they can also agree not to reveal even the existence of a potential acquisition. This initial step is generally completed *before* any substantive discussion occurs.

Confidentiality agreements may also include “standstill” and/or “no-shop” requirements. Standstill simply means

that the practice cannot make material changes, such as new capital commitments, sale of assets, or modification of the compensation system while in negotiations. Hospital standstill requirements are usually limited to those actions that could affect the subject acquisition, such as new affiliations with other medical groups or the purchase of ancillary services that may impact the practice.

No-shop provisions, sometimes referred to as Exclusivity Agreements, are becoming more common. Such provisions prohibit the practice from talking to other hospitals about being acquired; these provisions can also prohibit the hospital from discussing a merger or affiliation with other practices prior to the conclusion of current negotiations. While practices and hospitals sometimes resist such restrictions, in our view, these provisions can be critical to ensure that both parties are serious about, and committed to, the proposed relationship.

Letter of Intent or Term Sheet

The Letter of Intent (LOI), sometimes referred to as a term sheet, presents the basic terms and conditions under which further discussion and planning regarding the proposed affiliation will occur. This document is the most important one in the entire process in that it defines, as completely as possible, how the parties want to structure the deal and operate jointly after completing the transaction.

The acquisition of an oncology group often requires the establishment of work groups composed of representatives of both the hospital and the oncology practice. The work groups conduct the necessary analysis and provide recommendations to a steering committee that decides the contents of the LOI. After the LOI has been agreed on by leadership, legal counsel will guide the development of the definitive agreements. A term sheet skips most of the formalities and lists deal terms in outline or bullet-point format.

Creating the LOI or term sheet encompasses at least 80 percent of the time and energy that the transaction demands. Legal advice is required to resolve some of the issues, but LOI content should be directed by the principals of the practice and the hospital. Both entities should be closely involved in the process at all times. A summary of the key elements that should be addressed can be found in Table 3 on page 39.

Budgets or financial forecasts are not included as part of the LOI content. The process for developing and approving budgets should be addressed, but financial projections themselves are not generally included in the legal documents. That said, financial projections are an important part of the planning process and should involve both hospital and oncology practice representatives to ensure that the financial *pro forma* is realistic and attainable.

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Table 3. Key Elements in a Letter of Intent

Determine the employment model to be used.
Define physician employment specifics such as:
<i>Compensation</i> , including initial methodology and process to revise methodology.
<i>Other Employment Issues</i> , such as benefits, vesting period, handling of past deferred compensation (tax implications), PTO policies, etc.
<i>Term and Termination Provisions</i> , including potential sanctions and dismissal.
<i>Non-compete Clauses</i> , which go into effect after termination of employment.
Document the future governance structure. Define the authority of the hospital, oncology practice, and any board, operating committee, advisory council, or similar structure formed as part of the transaction. Outline the rights and obligations of each entity to:
Be informed of decisions of management or other governance bodies.
Advise decision makers prior to final decisions.
Approve specific policy or operational decisions.
Retain special majority or reserve powers regarding specified actions, such as sale of assets, changes to the compensation system, acquisition of other oncology groups, and purchase of a new EHR.
Documentation of valuation opinion(s), as required, for either physician compensation terms and/or practice acquisition terms.
Determine compensation and benefits for staff, including any employment agreements and severance packages.
Clarify operational issues and responsibilities, such as:
Will infusion services be provider-based (i.e., hospital-based)?
How will patient access be affected to meet hospital revenue cycle requirements?
How will staffing levels and budgets be determined?
What billing and EHR systems will be used, and who will support them?
How will physician recruitment and selection be managed?
Who will negotiate payer contracting for the physicians?
Who will manage the personnel decisions for front office, clinical, and administrative staff?
Document the timing and conditions under which either party could terminate the relationship and specify the provisions for unwinding the relationship if necessary.





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Definitive Agreements

After preparing a detailed LOI, the lawyers are asked to develop the necessary legal documents for signature based on the terms defined by the parties. The task may seem straightforward, but a number of documents need to be prepared, reviewed, revised, and signed before the transaction is complete. These include, but are not limited to:

- Acquisition Agreement (covering governance and operations)
- Asset Purchase Agreement
- Real Estate Lease Agreement
- Physician Employment Agreement
- Fair market value documentation
- Contract assignments
- Bylaws and Articles of Incorporation for any new physician entity
- Severance notification for group staff
- Escrow Agreements
- Promissory Note and Security Agreement.

Substantive issues often arise when these documents are prepared that require continuing negotiation and may necessitate a return to the negotiating table. In addition, due diligence reviews must be completed to determine that the financial and operational information used to fashion the agreement is accurate.

While the definitive agreements are being developed, each organization must undertake the process of securing internal approvals from its leadership. This process involves communicating the details of the proposed acquisition and its likely impacts to both the hospital board and each of the physician shareholders of the practice who will ultimately vote on the transaction. Whenever possible, both hospital and oncology group leaders should jointly make the presentations to both the hospital board and physician shareholders, as well as answer any questions that may arise.

Making It Work

The steps in completing the transaction may seem imposing, but once it is completed, the real work of transitioning to a cancer service line begins. While there are many “moving parts” to pay attention to, our experience shows that three factors are essential to success:

1. Expertise in oncology practice management and operations. You cannot place a hospital manager, even one with considerable ambulatory experience, in charge of an oncology physician network and expect good results. Respect the fact that specific expertise is required and find an experienced oncology executive to direct your efforts.


2. Physician leadership. The strategy is a partnership with physicians, so management and governance must reflect this commitment. Physicians with potential should be nurtured as managers and administrators and placed in decision-making roles in the cancer service line, the hospital, and at the system level.

3. Physician commitment to system-wide goals. When forming a cancer service line, too often behavior or performance expectations are minimized in order to be seen as “physician-friendly.” The reality is that providers in an integrated oncology network must be committed to the success of the service line and compliant with cancer center policies.

Given the major cultural differences between hospitals and physicians, achieving alignment is one of the most difficult challenges that either party will undertake. Many integration initiatives encounter conflict between the strategic goals and the entrenched culture of the organizations. It requires commitment and focus to work through these conflicts and form the new culture needed to sustain a cancer service line.

Is Integration Really Necessary?

When considering the steps involved in creating a cancer service line, the logical question is whether there are alternatives that are less time-consuming and expensive. While hospital and physician practice mergers are just one of a number of options for affiliation, in our view these remain the most viable structure in terms of effectiveness and stability for oncology services.

From an economic perspective, we believe there are two keys to success for an oncology program: 1) access to capital and 2) the assembling of a sophisticated management team that includes physician leadership. Both of these success factors are significantly affected by scale (i.e., hospitals and physicians that participate in a large, integrated, and disciplined cancer service line will be more competitive than the small, independent oncology groups). In terms of patient care, it will be very difficult for less integrated models (contractual or partnership arrangements) to be effective in the long term in achieving needed levels of coordination of care and documenting quality. While other affiliation models can be effective, especially as transitional structures, our experience points to the fact that comprehensive, economically integrated cancer service lines are the most efficient and appropriate for cancer care. 

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