Cancer Care and Accountable Care: The Complexity of the Future

Washington State Medical Oncology Society

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Max Reiboldt, CPA
President/CEO
Learning Objectives

1. Evaluate the effects of accountable care specific to oncology specialists
2. Identify physician-hospital alignment strategies for cancer care specialists and how to ensure successful alignment
3. Consider specific nuances relative to cancer care (such as the 340 B drug program)
4. Review case studies explaining how oncology specialists have successfully improved the value proposition to payers, physicians, patients and healthcare systems
Agenda

I. Accountable Care Era: Care Delivery Transformation

II. Oncology and the Accountable Care Era

III. Strategies for Navigating the Accountable Care Headwaters

IV. Case Studies

V. Q & A

VI. Appendix
I. The Accountable Care Era

Care Delivery Transformation
### Origins of the Accountable Care Era

#### Costs
- In 2011, healthcare spending hit a record high of $2.7 trillion with costs projected to surpass $3.0 trillion by 2014.
- All key players are facing challenges with controlling skyrocketing costs.

#### Reimbursement
- Continuous Medicare cuts to pay for specialty services.
- Reign of fee-for-volume declining.
- Payment changes: **sharing of savings; risk sharing; bundled payments; capitation**

#### Access and Demographics
- Baby boomers’ entry into Medicare.
- Medicaid expansion in 29 states (15 still deciding).
- Primary care development to promote overall wellness and prevention.

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**These changes are unprecedented**

**Accountable Care Era**
# The Accountable Care Era: Multiple Paradigm Shifts

## Traditional healthcare delivery model

<table>
<thead>
<tr>
<th>Fragmented care management treating primarily sick people</th>
<th>Episodes of care; utilization management</th>
<th>Production (volume)/Fee-for-service payments</th>
<th>Disjointed provider base</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated care management focusing on preventative care</td>
<td>Coordinated delivery of care rendering appropriate services at appropriate place and time</td>
<td>Performance (value); Quality/cost control; bundled payments; capitation; risk-based</td>
<td>Collaboratives: ACOs/CINs/PCMHs/QCs</td>
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## Accountable care era health care delivery
What is Driving the Change?

**Generational changes:**
- Work-life balance
- More women in medicine/healthcare

**Consumerism:**
- TIME – Bitter Pill
- New York Times – The $2.7M medical bill

**Lower costs:**
- 2014: Avg. increase in small business premiums in SC – 35%

**Improved quality:**
- 1999 IOM Report – 98,000 deaths due to preventable harm
- 2013 Journal of Patient Safety – 410,000 deaths due to preventable harm
What is Driving the Change? (cont’d)

• Economic and regulatory squeeze on hospitals and physicians

Physicians

• Cuts in payments
• Meaningful use requirements
• Performance reports

Hospitals

• “At risk”/value-based payments
• Loss of disproportionate share hospital payments
• No Medicaid expansion (in some states)
• Meaningful use requirements
• ICD-10
• Regional and national competition
Evolution of Payment Models

- **Fee-for-Service**: Providers paid a specified amount for each service provided
- **Pay-for-Performance**: Incentives for higher quality measured by evidence-based standards
- **Value-based Purchasing**: Percentage reimbursement at risk, earned back by high quality outcomes
- **Bundled Payments**: Single payment for episodes of treatment, shared by hospital and physicians
- **Shared Savings**: Percentage of savings from reduced cost of care shared with hospitals and physicians
- **Global Payments**: All services compensated in one payment that manages the patient across the delivery system
Transformational Care Delivery

**Tactical Initiatives**
- Medical Directorships
- Call Pay
- IT Implementation

**Strategic Initiatives**
- Clinical co-management agreements
- Professional services agreements
- Employment

**Transformational Initiatives**
- Collaboratives
- Clinically Integrated Networks
- Medical Homes
- Accountable Care Organizations
II. Oncology and the Accountable Care Era
Success Lies in the Balancing Act

Decreasing reimbursement rates (for professional services and therapy drugs)
Threats to ancillaries
Rising costs for purchasing drugs

Population health management
Patient satisfaction and outcomes
Cost-effective care
Changes in Oncology Reimbursement

Based on 2013 CMS Physician Fee Schedule

- Hematology/Oncology: 2%
- Radiology: -3%
- Interventional Radiology: -3%
- Nuclear Medicine: -3%
- Pathology: -6%
- Diagnostic Testing Facility: -7%
- Radiation Oncology: -7%

• Oncologists are realizing significant challenges as reimbursement rates decline across the board

• While the actual threat to an oncologist’s professional services is relatively minimal, declining reimbursement rates for ancillaries and chemotherapy/office-based drugs are creating the biggest splash
Oncology Drugs*

Drug payments were on a “buy and bill” system with reimbursement at Average Sales Price (ASP)+6% (i.e., cost-plus of 106%); currently the payment is ASP+4.3% and trending down.

Reimbursement for drugs continues to change as the high cost of cancer drugs comes increasingly under public and regulatory scrutiny.

Historically, the “buy and bill” method has not accounted for care coordination but value-based care is changing this.

*Revenue from drug reimbursement can account for nearly 65% of an oncologist’s annual compensation.
Cost of Cancer Drugs

Monthly and Median Costs of Cancer Drugs at the Time of FDA Approval
1965 - 2013

- Individual Drugs
- Median Monthly Price (per 5 year period)
340B Drug Pricing Program

Hospital/Private Practice

- The 340B program allows covered hospitals to extend its right to purchase and dispense 340B drugs to other facilities if they are considered an integral part of the hospital
  - Private practices (and other hospitals) aligning with 340B-eligible hospitals to benefit from this program

Freestanding Facilities

- Affordable Care Act allows freestanding cancer centers to qualify for 340B
  - City of Hope, Duarte, CA, and University of Miami, Miami, FL are the only 2 qualified centers, to date
Value-Based Reimbursement

Fee-for-volume will likely remain as the predominant form of reimbursement for a little while longer.

Value-based payments have already been introduced to the oncology world in the form of bundled payments.

Financial sustainability and strategic success can be achieved from an organization’s ability to find the “sweet spot” where they can capitalize on the existent FFS environment while preparing for the inevitable shift to fee-for-value.
III. Strategies for Navigating the Accountable Care Headwaters
Alignment/Integration Trends

**What They Entail:**
- Responding to market changes by collaborating with local providers and working as partners
- Laying foundation for integrated care

**What They Are NOT:**
- Employment
- Required loss of autonomy for independent physicians
- Degradation of income

**Why They Are Valuable:**
- Provides opportunities for maximizing revenue and pooling resources
- Boosts provider base to ensure care coordination and primary care development

**What the Future Holds:**
- Alignment occurring in a variety of ways
- Non-employment options for aligning exist: PSAs, JVs, etc.
- ACOs/CINs/QCs/PCMHs
Stage I: Alignment
Oncology Alignment Trends

- Over the last three years:
  - 242 medical oncology practices have been acquired by hospitals
  - 102 have merged or been acquired by another entity
  - An additional 323 are struggling financially
- Due to declining chemotherapy reimbursement rates:
  - Practices are consolidating
  - Oncologists are increasingly seeking hospital employment

Physician Employment – Then and Now

**THEN**
- Loyal referral base
- Profit centers
- High volume providers
- Market share
- Primary care
- Fee for service reimbursement
- Production based comp

**NOW**
- Integrated physician networks
- Quality improvement
- Cost Control
- PCMH networks
- Specialty ACOs (and disease-specific ACOs)
- Value – based reimbursement
- Value based compensation
- Population Health Management
- Triple Aim
Physician Employment – Then and Now (cont’d)

<table>
<thead>
<tr>
<th>THEN</th>
<th>NOW</th>
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<tbody>
<tr>
<td>• Operates independently and autonomously</td>
<td>• Understands his / her role in the system of care</td>
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<tr>
<td>• Highly productive proceduralist</td>
<td>• Leverages skills through a team of providers</td>
</tr>
<tr>
<td>• Cost not an issue</td>
<td>• Productive and cost efficient</td>
</tr>
<tr>
<td>• Considers standardization restrictive and valued for his / her innovative approach</td>
<td>• Doesn’t feel constrained by evidence based guidelines</td>
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<td>• Allowed to opt out of technology utilization requirements</td>
<td>• Facile with technology</td>
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<tr>
<td>• Loyal referral base</td>
<td>• Adaptive to change</td>
</tr>
<tr>
<td></td>
<td>• Population health manager</td>
</tr>
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<td></td>
<td>• Operations manager</td>
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### Traditional Alignment Models*

One of the most critical elements of the **Stage II: ACO/CIN Strategy** is in the **Stage I: Go-Forward Alignment Structure** between the parties involved.

<table>
<thead>
<tr>
<th>Limited Integration</th>
<th>Moderate Integration</th>
<th>Full Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Managed Care Networks</strong>: Loose alliances for contracting purposes</td>
<td><strong>Service Line Management</strong>: Management of all specialty services within the hospital</td>
<td><strong>Employment</strong>: Strongest alignment; minimizes economic risk for physicians</td>
</tr>
<tr>
<td><strong>Call Coverage Stipends</strong>: Pay for unassigned ED call</td>
<td><strong>MSO/ISO</strong>: Ties hospitals to physician’s business</td>
<td><strong>Includes the Physician Enterprise Model (PEM) and the Group Practice Subsidiary (GPS) model</strong></td>
</tr>
<tr>
<td><strong>Medical Directorships</strong>: Specific clinical oversight duties</td>
<td><strong>Equity Group Assimilation</strong>: Ties entities via legal agreement; joint practice ownership</td>
<td><strong>Employment “Lite”</strong>: Professional services agreements (PSAs) and other similar models (such as the practice management arrangement) – self-employed independent contractor</td>
</tr>
<tr>
<td><strong>Recruitment/Incubation</strong>: Economic assistance for new physicians</td>
<td><strong>Joint Ventures</strong>: Unites parties under common enterprise; difficult to structure; legal hurdles</td>
<td><strong>ACO/CIN/QC</strong>: Participation in a governmental or non-governmental organization focused on improving quality/cost of care; may be groups’ oriented or hospital/groups</td>
</tr>
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</table>

*Employment is not the only viable option*
Clinical Co-Management Arrangement Description

**Service Line Arrangement**
- The purpose of the arrangement is to reward physicians for their efforts in developing, managing and improving the quality and efficiency of the hospital’s service line.
- A contractual relationship between the hospital and the management entity results.
- Compensation is in part performance-based, tied to achievement of specific quality objectives.
- Some shared cost savings initiatives may also be included.

**Structure**
- Clinical co-management agreements offer an alternative to employment or a professional services agreement (i.e. employment “lite”) relationship, but still serve as a form of moderate alignment between two parties.
- CCMAs offer a way for hospitals to align with providers within its service line.
- CCMAs can also be in conjunction with a full alignment transaction in the form of a “wraparound.”

*Refer to Appendix for CCMA Models*
Service Line Co-Management Arrangement

Multiple co-management agreements between several independent oncology groups can be supported by one hospital entity.
CCMA Takeaways

**Size**
- All providers within the oncology service line (employed or contracted) can participate in the CCMA
- Multiple CCMAs may occur simultaneously

**Wraparound**
- “Add-on” services such as medical directorships, management services agreements, etc. may be incorporated into the CCMA structure

**Flexibility**
- Can be implemented with or without additional alignment strategies

**Service Line Stability and Improvement**
- Providers are incentivized and rewarded for driving the value proposition
Professional Services Agreements*: Overview

**PURPOSE**
• Achieve clinical and financial integration without employment

**RELATIONSHIP**
• Contracted services, multiple options

**SERVICES**
• Clinical (Professional) Services
• Wraparounds (administrative, call, quality, etc.)

**REMUNERATION**
• Typically paid on a top-line basis per wRVU. Wraparounds can take other forms of payment, if included.

*Refer to Appendix for PSA Models
PSA - Models

FOUR POSSIBLE SCENARIOS OF PSA MODEL

1. **Traditional PSA**: Hospital contracts with physicians for professional services; hospital employs staff and “owns” administrative structure
2. **Global Payment PSA**: Hospital contracts with practice for Global Payment; practice retains all management responsibilities
3. **Practice Management Arrangement**: Practice entity retained and contracts with hospital; administrative management and staff not employed by hospital, but physicians are employed
4. **Hybrid Model**: Hospital employs/contracts with physicians; practice entity spun-off into a jointly-owned MSO/ISO
PSA Arrangement

Hospital Supplies the Group with:
- License
- Provider-based status
- 340B pricing
- Space/equipment
- Staff (as required)

Payors

Group Provides the Hospital with:
- Physicians/mid-levels
- Non-clinical staff
- Professional services
- Administrative services

Note:
- All transactions (i.e., any monetary exchanges) must comply with FMV and CR provisions
Alternatives to Employment

1. Medical staff affiliation
   - Less relevant with move from inpatient to outpatient
   - Systems of accountability are lacking

2. Professional Services or Management Services Agreements
   - Less financial risk
   - More legal complexity
   - More difficult to achieve full clinical or cultural integration

3. Independent Physician Association (IPA)
   - Collaborative model among specialists
   - Entails a great deal of integration
   - Can lead into a clinically integration organization that does risk-contracting

4. Clinical Integration Programs aka ACOs
   - Cultural integration still critical
   - Legal, economic and clinical integration all possible within a clinical integration program
Benefits of Alignment

- **Financial Stability — Improved compensation**
- **Referral Network Stability — Improved or steady patient volume**
- **Achieve Strength in Numbers without Sacrificing Independence**
- **Group Purchasing Power (Eligibility for 340B Participation)**
- **Infrastructure Support — Administrative hassles off-loaded**
- **Recruitment and Retention — Private practices cannot compete**
- **Succession Strategy – No “cash-out” value in private practices**
Stage II: Accountable Care Strategy (Integration)
## Contemporary “Accountable Care Era” Models

<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>BASIC CONCEPT</th>
<th>COMPENSATION FRAMEWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient-Centered Medical Homes</td>
<td>• Team of providers and medical individuals collaborating to provide patient-centric care in a focused ambulatory care environment; can be part of ACO/CIN model</td>
<td>• Varying incentives based on contractual relationships with payers</td>
</tr>
<tr>
<td>Quality Collaboratives</td>
<td>• Consortium of providers focused on furthering the quality outcomes for a defined population</td>
<td>• Internal or external funding sources determine scope and structure of available funds</td>
</tr>
<tr>
<td>Clinically Integrated Networks</td>
<td>• Interdependent healthcare facilities form a network with providers that collaboratively develop and sustain clinical initiatives</td>
<td>• Incentive (i.e. at-risk) compensation based on achievement of pre-determined measures</td>
</tr>
<tr>
<td>Accountable Care Organizations</td>
<td>• Participating hospitals, providers, and other healthcare professionals collaborating to deliver quality and cost effective care to Medicare (and other) patient populations</td>
<td>• Incentive (and punitive) financial impacts based on cost savings and quality</td>
</tr>
</tbody>
</table>
The Ultimate Goal: Clinical Integration

Effective clinically integrated facilities meet the goals of the Institute for Healthcare Improvement’s Triple Aim:

1. Enhance the patient experience of care (including quality, access and reliability)
2. Improve the health of the population
3. Reduce (or control) the per capita cost of care
The ultimate structure is the “Care System,” which includes all providers (i.e., physicians, hospitals, ancillary services, etc.)
Patient-Centered Medical Homes: Not Just for Primary Care

• March 2011: the Community Oncology Alliance (COA) reported a significant shift in the site of care delivery from the community to institutionally based cancer programs

• In 2010, Consultants in Medical Oncology and Hematology (CMOH)—a 9-physician, single-specialty practice outside of Philadelphia—became the first oncology practice recognized by the National Committee for Quality Assurance as a level III PCMH
Clinically Integrated Networks/Organizations

- Primary focus of a CIN/CIO is to create a **high degree of interdependence among participating providers**
- Network of interdependent healthcare facilities and providers that collaboratively develop and sustain clinical initiatives on an ongoing basis through a centralized, coordinated strategy
  - Patient-centric
  - Structures may vary from provider to provider
  - Heavily reliant on robust IT infrastructure

Typical CIN Structure

- **Network Board (w/Sub-Committees)**
- **Hospital(s)**
- **Technology Quality Finance**
- **Long-term Care; Ancillary providers; Pharmacy**
- **Aligned network of providers***

*Alliance of specialist and/or primary care groups

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[Image of a flowchart depicting the typical CIN structure with connections to Hospital(s), Network Board (w/Sub-Committees), and long-term care providers, showing an aligned network of providers.]
Clinically Integrated Networks/Organizations (cont’d)

- Strong IT infrastructure for efficient and equal information sharing
- Requires integrated patient records with interoperability among many different providers, specialties and geographies
- Often involves robust disease registry and disease management information systems
- Compliance with regulatory and legal standards for IS/IT management critical, as well as requirement for solutions to meet Meaningful Use (MU) standards
- Communications capabilities & protocols critical in maximizing productivity of IS/IT solutions
Potential Oncology-Specific ACO Model

1. Defines optimal cancer care delivery process (incorporates oncology medical home processes)
2. Rationalizes resources – identifies optimal utilization of resources
3. Prepares and adjusts for “risk”

*Individual groups could be medical oncologists, radiation oncologists, surgical oncologists or a mix of each subspecialty
The Integration/ACO Strategy: Phases

Phase I: Initial Evaluation

• Assessment of current financial situation
• Determine the entity’s current operations, desired goals, AC readiness and future needs

Phase II: Identify Potential Partners

• Enter into discussions with local providers to evaluate potential for collaboration; partnerships
• Embrace a “strength in numbers” mindset

Phase III: Business Plan Formation

• Develop a comprehensive business plan based on analyses
• Include all strategic initiatives and implementation plans

Phase IV: Implement the Plan

• Initiate the implementation of the selected strategy
Existent “Progressive” Oncology Initiatives
Bundled Payments in Oncology

- Bundling is increasingly being suggested as one of the new payment models for controlling service line costs
  - Costs for cancer are estimated to reach $158 billion in 2020 (a 27% increase over 2010 totals)*
- Episode of care (bundled payment) is being developed to fit different specialties of cancer care
- In 2010, UnitedHealthcare launched a pilot program involving 5 oncology practice sites in a bundled payment program
  - Based on episodes of care defined into 19 cancer subcategories
  - Payment for care is fixed and drugs are reimbursed at manufacturer’s cost
  - UHC pays the practices a case management fee

*Source: National Institutes of Health
Bundled Payments in Oncology (cont’d)

Providers teaming up (instead of facing-off) to reduce variations in cancer care and develop best practices

Physician leadership and involvement in driving and assessing value

Value-based and data driven care represent cultural shifts that are significant undertakings but manageable

Providers were not responsible for drug costs but were given parameters by UHC based on thorough drug cost evaluations

UnitedHealthcare (UHC) Pilot Program Takeaways
Oncology-Specific Accountable Care Initiatives

Percentage of Oncologists Already Participating in an ACO or Planning to Join in the Following Year:

- **2012**: 9%
- **2013**: 29%

A 20% increase was realized in just one year. This trend is projected to occur at rapid pace as accountable care becomes more prominent and more payers switch to value-based payment models.

Florida Blue (Blue Cross Blue Shield of Florida) teamed up with Baptist Health South Florida and Advanced Medical Specialties (consisting of 17 physician practices) for the development of an oncology ACO:

- Focus on leukemia, lymphoma, breast cancer, lung cancer, colorectal, and male and female genitourinary cancers
- Is a shared savings plan with shared risk for a defined oncology population

Source: Medscape, “2013 Oncologist Compensation Report”
Oncology-Specific Accountable Care Initiatives (cont’d)

• Aetna coordinated a partnership with the US Oncology Network’s Texas affiliate to create an ACO
• Aetna cites a 12% lowering in costs for lung, breast, and colorectal cancer in its shared saving model
• Blue Cross Blue Shield is sponsoring other ACO programs in California, Maryland, Michigan, New Jersey, Tennessee, and South Carolina

Progressive care delivery models are quickly gaining momentum as vehicles for controlling skyrocketing costs. Because of the significant expenses associated with oncologic care (coupled with the projected rise in cancer prevalence), doing nothing is not a viable option for oncologists.
Deriving Success
Consistently Strive for the Value Proposition

- Increase Quality
- Decrease Costs
- Deliver Value
Gain Volume Through Value

<table>
<thead>
<tr>
<th>Quality Enhancement</th>
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<tbody>
<tr>
<td>• Develop quality initiatives for safety, outcome and satisfaction</td>
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<tr>
<td>• Engage physicians in metric development process</td>
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<tr>
<td>– Process <strong>and</strong> outcomes measures</td>
</tr>
<tr>
<td>• Practice evidence-based medicine</td>
</tr>
<tr>
<td>– Establish protocols and best practices</td>
</tr>
<tr>
<td>• Remember customer service</td>
</tr>
<tr>
<td>• Utilize a population-health mindset</td>
</tr>
<tr>
<td>• Track and assess</td>
</tr>
<tr>
<td>• <strong>You can’t change what you can’t measure</strong></td>
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<table>
<thead>
<tr>
<th>Cost Reduction</th>
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<tbody>
<tr>
<td>• Track and control medical utilization</td>
</tr>
<tr>
<td>• Focus on prevention and chronic disease management</td>
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<tr>
<td>• Utilize EHR</td>
</tr>
<tr>
<td>• Coordinate care</td>
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<tr>
<td>• Fill in gaps in the care continuum</td>
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Barriers to Success

- Being competitive and compliant
- Timing volume to value transition
- Hospital-physician distrust
- Fail to recognize full breadth of integration
- Fail to understand transformational processes
### What’s Best for the Patient?

**High quality, patient centered care**

<table>
<thead>
<tr>
<th>Easily accessible</th>
<th>Coordinated</th>
<th>Cost efficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locations, strong primary care base</td>
<td>IT systems – EMR, HIE</td>
<td>Care guidelines</td>
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<tr>
<td></td>
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<td>Case management/ navigation</td>
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<td>Operational programs: LEAN, Six Sigma, Flow Variability Management</td>
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What’s Best for the Patient? (cont’d)

High quality, patient centered care

**Comprehensive**
- Pre-acute, acute, post-acute
- Breadth of specialization

**Personalized**
- Tailoring care to the unique needs of each patient
- Mass customization
How Will this Play Out?

Value based reimbursement will dominate
- Systems that can integrate physicians into their business model the best will also succeed the best

Savings will capitalize re-tooling of the industry
- Value production versus volume production

Separation of primary care from specialty model
- Hospital owned PCMH networks – focus on Population Health Management
- Specialty specific or multi-specialty IPAs – focus on high value (quality / cost) care processes and procedures
  - Regional or even national
Incentivizing Success
Reinforcing the Value Proposition

• Design a compensation structure that:
  – Motivates physicians with financial incentives
  – Creates some level of risk
  – Engages physicians
  – Is attractive for recruitment and sufficient for retention
  – Solicit provider input for developing the structure
Compensation Framework: The Salary Model

- **Standard Formula:**

\[
\text{Salary} + \text{Possible Production Incentive Payment} = \text{Compensation}
\]

Non-productivity incentives have not always been included.
Compensation Framework: The wRVU Model

• Standard Formula:

\[ \text{wRVUs} \times \text{Conversion Factor} = \text{Compensation} \]

Non-productivity incentives have historically been tough to include
Compensation Framework: The Distributable Net Income Model

**Revenue:**
- Professional Fees (Fee for Service)
- ACO Income
- Call Coverage
- Third Party Payer Initiatives
- Capitation Fees
- Other

+ Non-Productivity Incentives are embedded into overall model

**Overhead:**
- Direct Expenses
- Indirect Expenses
- Physician Base Salary
- Physician Benefits

= Distributable Net Income
What Does This All Mean for Oncologists?

- Compensation is often a great motivator
- Hospital and practice administrators must design a plan that incentivizes volume and value
- **Five Key Tenets for Establishing a Sustainable Compensation Structure:**
  - Regularly assess current structure for scalability and adaptability
  - Bring physicians into the discussions and educate them on options
  - Establish metrics for success and methods for tracking them
  - Maintain regulatory compliance at all times
  - Non-productivity incentives:
    - Choose no more than three key areas
    - Let system dictate some, physicians choose some
    - Pay no more often than semi-annually
    - Establish scoring mechanism as objectively as possible
Keys to Success

Understand the difference between employment and integration and recognize that one does not equate with the other.

Align compensation and reimbursement models.

Evaluate physician employees as to their overall value to the system.

Make it a partnership not an employer – employee relationship.

Utilize financial and non-financial rewards / incentives.
Keys to Success (cont’d)

- Always stay within limits of fair market value and commercial reasonableness
- Allow for retained autonomy / shared decision making
- Be transparent in order to build trust
- Strive for responsiveness and flexibility
- Understand the unique nature of physician practice management – “physician practices are not small hospitals”
IV. Case Studies
## Case Study 1

<table>
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<tr>
<th>Client</th>
<th>Target #1</th>
<th>Target #2</th>
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<tbody>
<tr>
<td>A large non-profit health system in the Southeast with multiple acute-care hospitals spread throughout the region</td>
<td>A large (&gt;10 physicians) Oncology group with numerous offices, surgery centers and multiple office-based ancillary services throughout the market area, working with every major health system in the area</td>
<td>A small (&lt;10 physicians) Oncology group with a few offices, 1 surgery center and multiple office-based ancillary services spread throughout the market</td>
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</tbody>
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Case Study (cont’d)

**Situation**
- Hospital pursued a transaction with both target groups that consisted of 1) PSA; 2) purchase of equity stake in surgery center(s); and 3) purchase of ancillary services

**Outcome**
- Hospital completed portions of the overall transaction, which will continue for up to five years, with additional tranches of equity stake purchases being completed throughout that time*

**Coker’s Role**
- Lead transaction advisor to the Hospital, which included structuring the PSA and ancillary purchase deal(s), conducting the due diligence and valuations related to the deal(s), negotiating the transactions and overall management of the transactions processes

*In addition to the PSA, the Hospital purchased all office-based ancillaries (i.e., pathology, lab, imaging, infusion, etc.) but did **NOT** purchase all of the surgery centers. They did purchase equity stakes in them, which constituted a joint venture on those ASCs going forward.*
Case Study 1 (cont’d)

• Key Takeaways:
  – Oncology service line (Practice) is responsible for all operating expenses
  – Hospital pays Practice base fees for the services performed by physicians
  – Practice continues to bill under its current entity name; however, receivables belong to Hospital
  – Hospital purchases drugs under 340B drug program, on behalf of practice (Practice sells infusion services to Hospital but provides management oversight for same)

• Oncology group would provide the following services:
  – Medical and surgical oncology services
  – Clinical management and coordination
  – Administrative, supervisory, teaching and research functions

• PSA with Hospital entails fully integrating with the Hospital’s infrastructure without sacrificing Practice independence, autonomy and physical entity

• **Signifies the first stage of the overall Accountable Care Era Strategy**
Case Study 2: CMOH

**Situation**

- CMOH is a 10-provider independent hematology-oncology practice in Delaware County, PA
- CMOH had 3 health system affiliations and provided IP cancer care within 7 hospitals among those systems
- CMOH had 4 outpatient offices
- After implementation of their EHR system in 2006, CMOH essentially went paperless and had interfaces with the lab, radiology, pathology and medical records departments of their affiliated hospitals
- Eventually, CMOH launched MOSAIC, a basic oncology EMR system that tracks and reports patient care data
- Through the use of technology, data management and evidence-based medicine, CMOH providers were collaborating to monitor and refine the care delivery process

**Approach**

- Addressed a wide range of topic areas, projects and other planning facilitation functions (financial, operational, technology, personnel, etc.)
- A team of oncologists achieved true clinical integration by systematically collaborating to collectively improve the quality of care provided and achieve cost savings from increased efficiencies and standardization
- Providers worked together to develop appropriate and meaningful metrics for tracking performance
- Utilized preventive measures, patient engagement and education

**Outcome**

- In 2010, CMOH received NCQA’s PCMH designation for creating a care delivery model that was fully patient-centric and coordinated among all parties
- Since its inception, CMOH’s PCMH has realized significant improvements in financial margins and patient outcomes
Case Study 2 (cont’d)

• Key Takeaways:
  – CMOH achieved cost savings from reducing staff FTE requirements and increasing operational efficiencies from reducing variations in day-to-day activities
  – Increased efficiencies allowed the Practice to see more patients in the same amount of time
  – Patient outcomes improved with lowered annual ER referrals and hospital admissions declining to 9.7% (despite rise in patient volume) in 2010
  – Real quality outcomes achieved: By changing their treatment of gastritis in patients on chemotherapy, they lowered the C. Difficile rate at one of their primary hospitals by 50%
  – Basically, this group of specialized providers achieved the basic value proposition through the delivery of quality and cost-effective care

• Signifies the second stage of the overall Accountable Care Era Strategy where integration serves as the vehicle for providing (and refining) care based on data-driven metrics and outcomes for a defined patient population.
V. Q & A
Max Reiboldt, CPA
President & CEO
Coker Group Holdings, LLC
T: 678-832-2007
mreiboldt@cokergroup.com
VI. Appendix
CCMA: MODEL A

Existing Oncology Physician Group

Management Agreement

Hospital (Oncology Service Line)

Management Fees

Management Services
CCMA: Model B

Physician Ownership

Newly-Created Management Entity

Management Fees

Management Agreement

Hospital (Oncology Service Line)

Management Services
CCMA: MODEL C

Joint Venture Management Entity

- Hospital Ownership
- Physician Ownership

Management Agreement

Management Fees

Management Services

Hospital (Oncology Service Line)
CCMA: MODEL D

Management Agreement between Hospital and Practice for a subset of management services and payment of a part of the total service line management fees
# PSA – All Models

- Flexibility in structure
- Opportunities to increase and enhance bottom-line for both hospital and the practice
- Stability in relationship with hospital
- Bonus opportunities for exceptional performance
- Opportunities to expand services together without being fully aligned (i.e., employment)
- Easy segue to full employment for physicians and staff
<table>
<thead>
<tr>
<th></th>
<th>Global Payment PSA</th>
<th>Practice Management Arrangement</th>
<th>Traditional PSA</th>
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<tbody>
<tr>
<td>Physicians Employed by Hospital</td>
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<tr>
<td>Physicians Employed by Practice</td>
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<td>Staff Employed by Practice</td>
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<tr>
<td>Real Estate Owned by Hospital</td>
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<td>Real Estate Owned by Practice</td>
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<td>Non-Ancillary Medical Equipment Owned by Hospital</td>
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<td>Non-Ancillary Medical Equipment Owned by Practice</td>
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<td>Hospital/Hospital Affiliate Physician Benefit Plans Utilized</td>
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<td>Practice Physician Benefit Plans Utilized</td>
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<td>Hospital/Hospital Affiliate Billing Tax ID Used</td>
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<td>Practice Billing Tax ID Used</td>
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<td>Hospital/Hospital Affiliate Retains A/R (post-alignment)</td>
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<tr>
<td>Practice Retains A/R (post-alignment)</td>
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<td>Managed Care Contracting Negotiations Completed by Hospital</td>
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<tr>
<td>Managed Care Contracting Negotiations Completed by Practice</td>
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</tbody>
</table>

*Depends on negotiated agreement
PSA – Traditional Model

- Hospital contracts with physicians for professional services
  - As such, the physicians are not employed by the hospital, but remain employed by the practice
- However, the hospital employs all support staff
  - This typically includes practice administrators/management staff
- Under this model, many of the operational and administrative duties become the responsibility of the hospital, as opposed to the practice
  - Ancillaries are usually acquired by the hospital
Payers

ABH Health System “System”

DEF Medical Group (“Group”)

• Independent contractors as a Group
• Group includes all providers
• Payment to Group for professional services equal to net collections less direct costs paid by System
• Includes site of service differential for professional services
• Annual fixed amount to be paid to Group for value of ancillary services
  • set in advance
  • not based on volume of referrals
• Lease paid by System
• Lease expense deducted from professional service revenue to be paid to Group

Independant Contractor

• Lease
• Purchase or Lease

System Employees

Group Staff

• System employees
• Fully loaded expense deducted from professional service revenue to be paid to Group

System Outpatient Services

Group Ancillary Services

• System hospital outpatient based services
• Ancillary staff are employees of System
• Not always purchased by System, but included in comp via an annual fixed payment to Group set in advance

Real Estate

• Lease paid by System
• Lease expense deducted from professional service revenue to be paid to Group

Operating Expenses

• Includes:
  • lease / depreciation expense
  • Other direct operating expenses
  • Deducted from professional service revenue to be paid to Group

ABC Health System

Professional and technical fees

Ancillary Services

Operating Expenses

Chart showing the flow and relationships between different components of the PSA – Traditional Model, including Group Staff, Group Ancillary Services, System Employees, System Outpatient Services, Real Estate, and Operating Expenses, with arrows indicating the flow of revenue and expenses.
PSA – Global Payment Model

• Hospital engages practice (who continues to employ physicians) to provide comprehensive services through a PSA
  – Practice is compensated on a global basis
  – Independent practice maintained
• Practice is independent contractor
• Physicians still “employed” by practice, as are the staff
• Self-employed status: no benefits from hospital
• Comprehensive alignment strategy requiring less integration than employment
PSA – Global Payment Model (cont’d)

- Practice invoices hospital for actual services rendered
  - Usually in wRVUs, converted to dollars
- Hospital pays practice directly without any withholding
- Files 1099 with IRS: practice responsible for withholding taxes from physician
- Characteristics of employment but stops significantly short of employment
PSA – Global Payment Model (cont’d)

**Hospital Board**
- Asset Ownership/Lease
- Contracting
- A/R Owned

**Medical Group Board**
- Group Governance
- Physician Hiring/Termination
- Income Distribution
- Clinical Practice/Quality
- Malpractice
- Management and Staffing
- Billing (3rd-party agent)
- IT Support

**PSA**
- Membership
- Compensation
- Clinical Services & Non-compete Agreement

**Management Committee**
- Approves Strategy/Finances
- Oversees Operations/Business Planning
- Establishes Compensation Principles
- Achieves Value-Exchange Objectives
- Is Typically Split 50/50 Between Hospital and Medical Group

**Hospital (Integrated with Physician Division Infrastructure)**

**Medical Group (For-Profit Entity)**
PSA – Global Payment Model (cont’d)

Services to be provided could include:

- Multi-specialty diagnostic and procedural services
- Clinical management and coordination
- Administrative, supervisory teaching and research functions
- Medical directorships
- Complete service line and clinical co-management
- Call responsibilities
- Shared cost savings
- Quality incentives
PSA – Global Payment Model (cont’d)

- Hospital compensates practice for professional fees and other services performed at and for the hospital
  - Medical directorships, call, service line/clinical co-management, etc.
  - Paid at FMV/ commercially reasonable rates
- Ancillaries may be sold/leased to hospital who bills at HOPD rates
- Hospital could bill at PBR (provider based rates)
  - This is not often done under the Global Payment model, however
  - More likely under the Traditional PSA
PSA – Global Payment Model (cont’d)

- Accounts receivable owned by hospital
- Fee structure established by hospital
- Payer contracts negotiated by hospital
- Practice continues to perform the billing services for the hospital as a third party agent (at FMV rates)
• Overhead expenses paid by practice
• Hospital provides base fee that should cover all expenses including physician compensation*
  – Potential for bonuses in addition to base fee
  – Ancillary services included (if included in hospital revenue base, must be considered in physicians’ compensation, but **not** directly tied to same)

* At wRVU conversion factor rates, tiered for higher production levels, separately calculated by specialty
Global payment rate *may*:

- **Option One**: Include physician compensation/benefit expenses and overhead expenses in a single rate/wRVU

- **Option Two**: Include separate payments for each component
  - Often, the overhead component is paid based on a budgeted amount, rather than on an wRVU basis
PSA – Global Payment Model: Benefits

- Physicians maintain independence from hospital
- Flexibility in structure
- Opportunities to increase and enhance bottom-line for both hospital and the practice
- Stability in relationship with hospital
- Bonus opportunities for exceptional performance
- Opportunities to expand services together without being fully aligned (i.e., employment)
- Easy segue to full employment
Physicians retain ownership of their practice infrastructure.

Physicians operate as the managers of the practice, providing all administrative services, space, equipment, and support staff.

The hospital contracts with the practice entity for these services and pays a fair market value (FMV) fee.

The compensation structure for the employed physicians is a productivity-based system.

The arrangement can be easily dissolved, as the practice entity stays outside the hospital control structure.

**Medical Group Infrastructure**
- Practice Management
- Billing/Collections

**Physicians**
- Compensation
- Benefits

**Hospital**

**Ownership**

**Employment**