Association of Community Cancer Centers

27th National Oncology Economics Conference

The Provider Based Clinic Model: A Powerful Strategy for Cancer Program Growth and Physician Alignment!

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Association of Community Cancer Centers

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Provider Based Clinic

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Access to this presentation:

- ACCC website, www.accc-cancer.org
- Arvina Group, LLC website, www.arvinagroup.com:
  - "About Us", then
    - "Publications", then
      - Scroll to "Cancer Presentations and Publications".

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Session Objectives:

- The purpose of the model and goal alignment.
- Define the provider based clinic model and its application.
- Describe the planning process.
- Describe the detailed operational, management, and compensation elements of the model.

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Target Audience:

- Physician practice leaders.
- Cancer program leaders.
- Hospitals and health systems leaders.
- Academic medical centers leaders.

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Backdrop: Economic Overview

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Economic Overview:

- Both physician and hospital payments systems are ***under attack.***
- Cancer program physicians practices (medical oncology, surgery) are currently and will continue to be economically vulnerable:
  - First half of 2010, many practice incomes are below comparable period in 2009.

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Economic Overview (continued):

- National overview: oncology practices & cancer programs:
  - The future in Medicare:
    - More "*Global*" fee contracting and other "incentives" to reduce utilization (cost).
    - Strategic implications for medical oncology practices and cancer programs:
      - ***Cost sharing/significantly lower cost structure are required as future margin potentials shrink.***
  - Other payors will/are following Medicare's lead.

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Economic Overview (continued):

- Income challenges facing physicians:
  - Annual "updates" (aka "revisions") resulting from changes in the physician practice payment formula will continue to introduce changes that reduces practice income ***and***,
  - RB-RVU for 2010 and 2011 has programmed an annual decline due to mandated Medicare budget neutrality requirements (statutes) ***and***,

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Economic Overview (continued):

- **Income challenges facing physicians:**
  - **Healthcare reform, to the extent that it occurs, has generally incorporated a 1.5% - 2.0% inflation factor for physician reimbursement *and*,**
  - **Resolution of the SGR (sustainability growth rate factor) funding issue is uncertain. SGR annualized impact on physician income:**
    - **2010: *-10%+* (for the last half of 2010)???**
    - **2011: *-25% - 30.0%* (est'd).**

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Economic Overview (continued):

- **Conclusions: Less $'s per capita for physicians and hospitals in the future:**
  - **Medical oncology reimbursement programmed to be *discounted annually at least at a moderate rate* (approximately 6% through 2015).**
  - **Surgery.**
  - **Radiation oncology.**

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Economic Overview (continued):

- Conclusions: Less $'s per capita for physicians and hospitals in the future:
  - Inflation on expenses + Medicare discounts + other payor discounts = at least 4% - 8%+ annual discount on cancer program physician income (constant volume).
  - Future impact of SGR unknown at this time.
  - Healthcare reform provides minimal increases for physician income.
  - Most physicians indicate they have little if any capacity to increase production (work longer hours +/- increase productivity) to offset income declines.

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Bottom Line:

- **Successful cancer programs will be strategically and economically aligned with program physicians.**
- **Alignment alternatives:**
  - **Status quo private practice structure (sit out the storm).**
  - **Employment.**
  - **JV's (limited number and dwindling) provide limited value.**
  - **Professional Services Agreements:**
    - **Provider Based Clinic model (employment - like while retaining a private practice structure).**
    - **Co-management (limited returns).**
    - **Some others (variations of a theme).**

***Any decision about a future alignment is a strategic decision that the practice makes*.**

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Alignment

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Underlying Assumptions Related to Alignment:

- Physicians desires to explore alternatives to their current unaligned private practice structure to assure the practice's survival (assumes the current stand alone private practice structure will not yield long term financial viability).
- Partnering with a hospital to pursue an alignment alternative is both an elective and a deliberate business strategy (priority decision for survival).

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Alignment Goals:

- Create value (profitable, fair, and equitable) to the parties.
- Consistent application of standardized systems, processes, and management.
- Legal structure established; consistent with Fair Market Value (FMV) principals.
- Align incentives and goals (contributes both to hospital program and physician practice growth, clinical integration, quality, and financial performance).
- Create a group practice setting within a hospital managed model (define the operating and management principles for physicians to practice).

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Guiding Principles for Alignment and Arrangements:

- Leadership and fiduciary:
  - Abides by state and federal regulations.
  - Promotes fiscal responsibility.
  - Simplicity; easy to understand and implement.
  - Transparent.
  - Fair, reasonable and, aligns with market conditions.
- Compensation:
  - Based on fair market value principles.
  - Include incentives, where applicable (base, bonus, performance and quality, strategy).

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Guiding Principles for Alignment and Arrangements:

- **Respect:**
  - Value the physician.
  - Value the cancer program and hospital.
- **Collaboration:**
  - Contributes to the cancer program vision.
  - Creates incentives for program and practice growth.
  - Supports, is not in conflict with the multidisciplinary model of care.

Understanding the Provider Based Clinic Model

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Requirements for Success:

- **Team approach to discussions and decision making.**
- **Accurate data.**
- **Transparency (data, discussions, decision making).**
- **Balance within the arrangement for risk and reward.**
- **Healthcare business legal counsel expertise.**
- **Third party facilitator.**

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The Provider Based Clinic Model:

- Simulates employment without becoming an employee. Broad applicability to a range of specialties.
- Follows detailed discussions; elected by the parties as the preferred alignment arrangement.
- Is a *transition*, not endpoint, arrangement.
- Hospital operates the operations (procedures and E & M activity) of the physician's practice as a hospital department (provider based clinic).
- Legal structure = contract (PSA/professional service agreement). The physician is also an active partner in clinic management.

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The Provider Based Clinic Model (continued):

- Hospital departments and facilities reported as provider-based (APC payment) on the Medicare cost report (after applying for and receiving such status), are located in the main building, on the hospital's main campus, or off campus, and are fully integrated into the hospital's licensure, governance, and professional supervision.
- Entities seeking provider based status must satisfy specific Medicare requirements, most of which are intended to demonstrate functional, operational, management, quality, and financial integration between the hospital and the entity seeking provider-based status.

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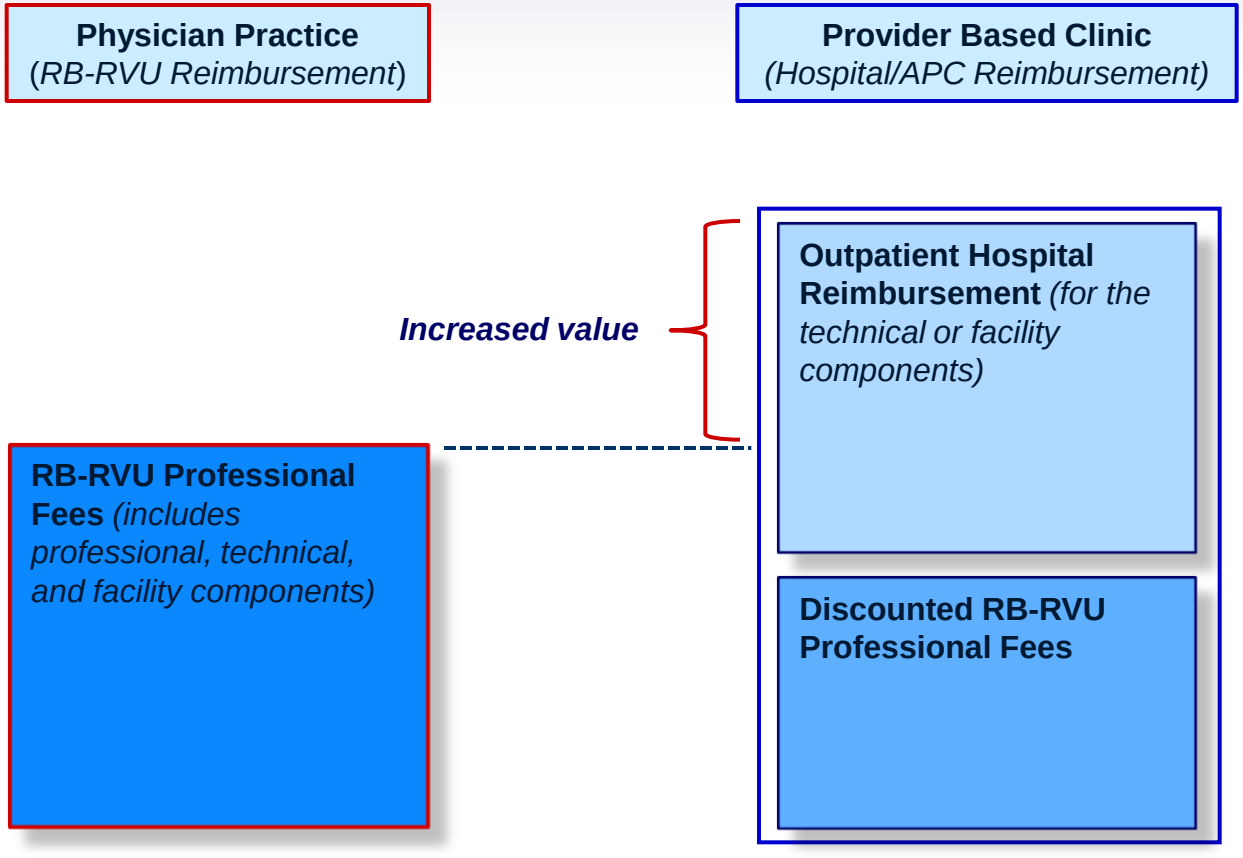
The Economics of Resource Based and Provider Based Reimbursement (*at the moment*)



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Why should a practice and a hospital consider the provider based clinic model?

- An alternative to employment if such is not desired.
- Allows the practice to retain its private practice structure by contracting as a provider with the hospital.
- An alternative practice income model (potential to provide increased value over the current mechanism).
- Creates a common strategic platform to align practice/hospital-program goals and achieve economic goals between the parties.
- Fosters more effective cancer program management.
- The model lends itself to facilitate clinical integration.
- Position the practice and the hospital to address future reimbursement changes and models.
- Consistent with most/all strategies to address healthcare reform.

Provider Based Clinic

How does a private practice participate in a provider based clinic?

- **The practice enters into a professional services agreement (contract) with a hospital to provide services at the clinic.**
- **The specific terms of the contract (practice's role in management, staffing, compensation, term/length of the contract, etc.) are discussed and negotiated between the practice and the hospital.**

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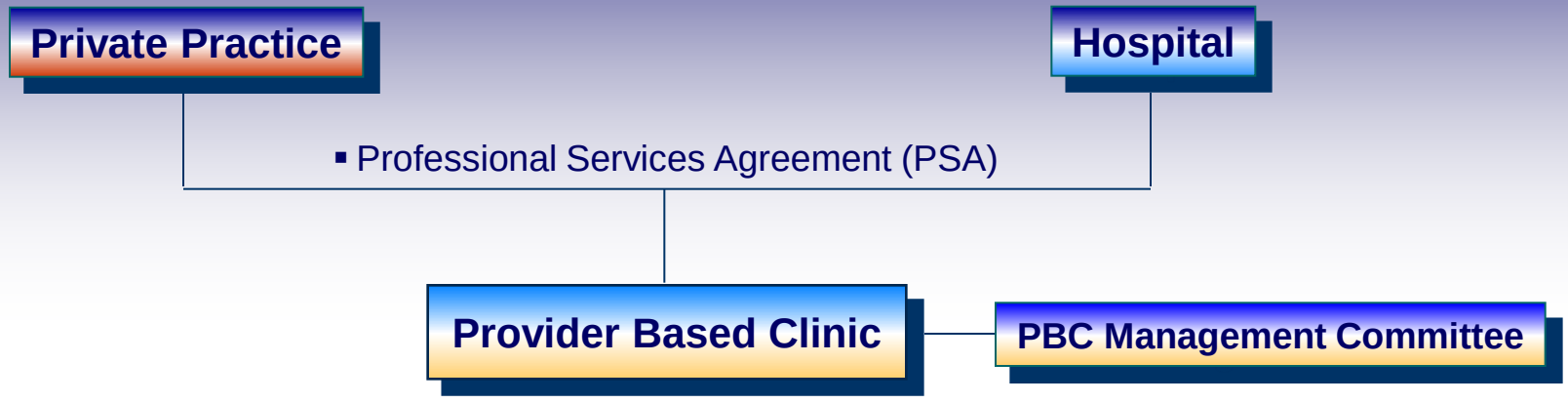

- Clinic meets CMS Provider Based Clinic rules.
- Clinic provides patient evaluation, consultation, and infusion therapy services. For medical oncology, potential to combine the practice's and the hospital's infusion therapy operations.
- Hospital and private practice group enter into a PSA. Physicians provide professional services at the clinic. Among a number of terms, the agreement details the compensation arrangement, clinic management, and medical directorship. Non-practitioner clinical staff are hospital employees. Management/administrative staff can be employed by the practice and contracted to the hospital.
- PSA is consistent with federal and state statures and regulations.
- Hospital bills the professional, technical, and facilities fees, and pays the physicians a fair market value fee (typically on a wRVU basis).
- Hospital manages the clinic and hires a manager (via employment or contract).
- Management Committee is established and meets routinely to address planning and operational topics. Also discusses annual contract review and renewal (including compensation arrangement).

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- **Options when configuring the (flexible) arrangement:**
  - **Clinic Professional Billing: Performed by the hospital *or* performed by the practice and reimbursement assigned to the hospital.**
  - **Inpatient Professional Billing: Can be added to the PSA arrangement. Performed by the hospital *or* performed by the practice and reimbursement assigned to the hospital.**
  - **Non-clinical Staff: Can be practice employees and leased to the hospital/clinic (at FMV) *or* can be hospital employees.**
  - **Clinic Equipment: Practice can continue to own and then lease to the hospital (at FMV), hospital can buy its own, *or* the hospital can purchase it from the practice (at FMV).**

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- Sources of revenue for the practice under a provider based clinic arrangement:
  - Clinical production (compensation for wRVU's).
  - Compensation for a role in clinic management.
  - Compensation for medical directorship (s).
  - Lease of any employees and/or equipment to the hospital to operate the clinic.
- Practice continues to bill for other professional services not involved with the clinic.

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Potential *advantages* of a PBC:

- **Builds on economies of scale between the parties.**
- **Contributes to more effective cancer program management:**
  - **Opportunity for joint hospital – physician management and participation in operational and planning decision making.**
- **Greater hospital flexibility to support physician practices and program services.**
- **Facilitates clinical integration initiatives.**
- **A test for an employment model.**

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Potential *dis*advantages of a PBC:

- Requires a hospital physician practice management distinctive competency (which may not exist).
- Physicians may not trust the hospital's ability to manage services within their practice more effectively than they do.
- Increased and more "formal" management requirements as a result of the arrangement.
- Physicians loose direct control of some practice clinical staff as a result of the CMS requirements.

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Potential *dis*advantages of a PBC (continued):

- The compensation discussion (part of the PSA) between the hospital and practice can be a challenging activity.
- On site pharmacist (incremental cost) may be required (yet financially manageable) for infusion therapy.
- Split billing can result in some negative patient impressions if not designed correctly.
- Understand that the arrangement is a transition structure.

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Typical key discussion points for a physician practice when considering the provider based clinic model:

- **Compensation (amount, mechanism, does it provide value over historical method?).**
- **Billing (who performs).**
- **Control (amount and structure) in clinic management and operations, and with staff.**
- **Impact of the clinic on the image of the practice.**
- **Clinic EMR minimizes change requirements.**
- **Hospital use and potential acquisition of the practice's EMR if a recent investment.**

Planning Considerations

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Five essential steps to plan the provider based clinic:

1. **Explore the conceptual feasibility between the parties.**
2. **Detailed feasibility assessments.**
3. **Develop a term sheet.**
4. **Draft the contract.**
5. **Develop an operations and implementation plan.**

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Developing and planning the provider based clinic:

1. **Explore the conceptual feasibility between the parties:**
   - **Education; hospital and the practice discuss the model, how it might work in their setting, and the advantages and disadvantages of the model.**
   - **Decision Point: "Go/No Go".**
2. **Detailed feasibility assessments:**
   - **Enter into an *exclusive* MOU/CA.**
   - **CMS provider based requirements assessed.**
   - **Physician practice's income simulation (value index).**
   - **To the hospital/cancer program.**
   - **Decision Point: "Go/No Go".**

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Key assumptions for the hospital financial feasibility analysis and physician income simulations:

1. **Hospital assume some drop off in wRVU's.**
2. **Assume the hospital based and RVU based payment policy gap will narrow (Medicare and commercial payments for drugs, uniform Medicare pricing, etc.).**
3. **Physicians test changes in the wRVU compensation rate (due to changes in clinical productivity and future FMV rates).**
4. **Both the hospital and physicians develop alternative risk assessment scenarios ("what if scenarios).**
5. **Hospital build in a contingency expense (1.5% - 3.0% of operating expenses, excluding drugs and depreciation).**
6. **Be prudent and reasonable with hospital overhead allocation.**

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Developing and planning the provider based clinic:

3. **Develop a term sheet:**
   - Confidential and non-binding discussion document.
   - Discuss the 5 – 10 priority terms of the proposed arrangement.
   - Compensation is a key term 99%+ of the time.
   - Control is the other key term.
   - Decision Point: “Go/No Go”. Agreement on the terms?
4. **Draft the contract:**
   - Review, discuss, and negotiate.

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Developing and planning the provider based clinic:

5. **Clinic planning (operations and implementation):**
   - **Concurrent with or precede #4.**
   - **Employee transition.**
   - **Management transition.**
   - **Operations**
   - **Financial services (budget, charge master, contracts, etc.).**
   - **IT (registration, billing, scheduling, and EMR).**
   - **Establish the management committee (can initially serve as the planning and transition oversight committee).**
   - **Finalize and execute the contract, implement the clinic.**

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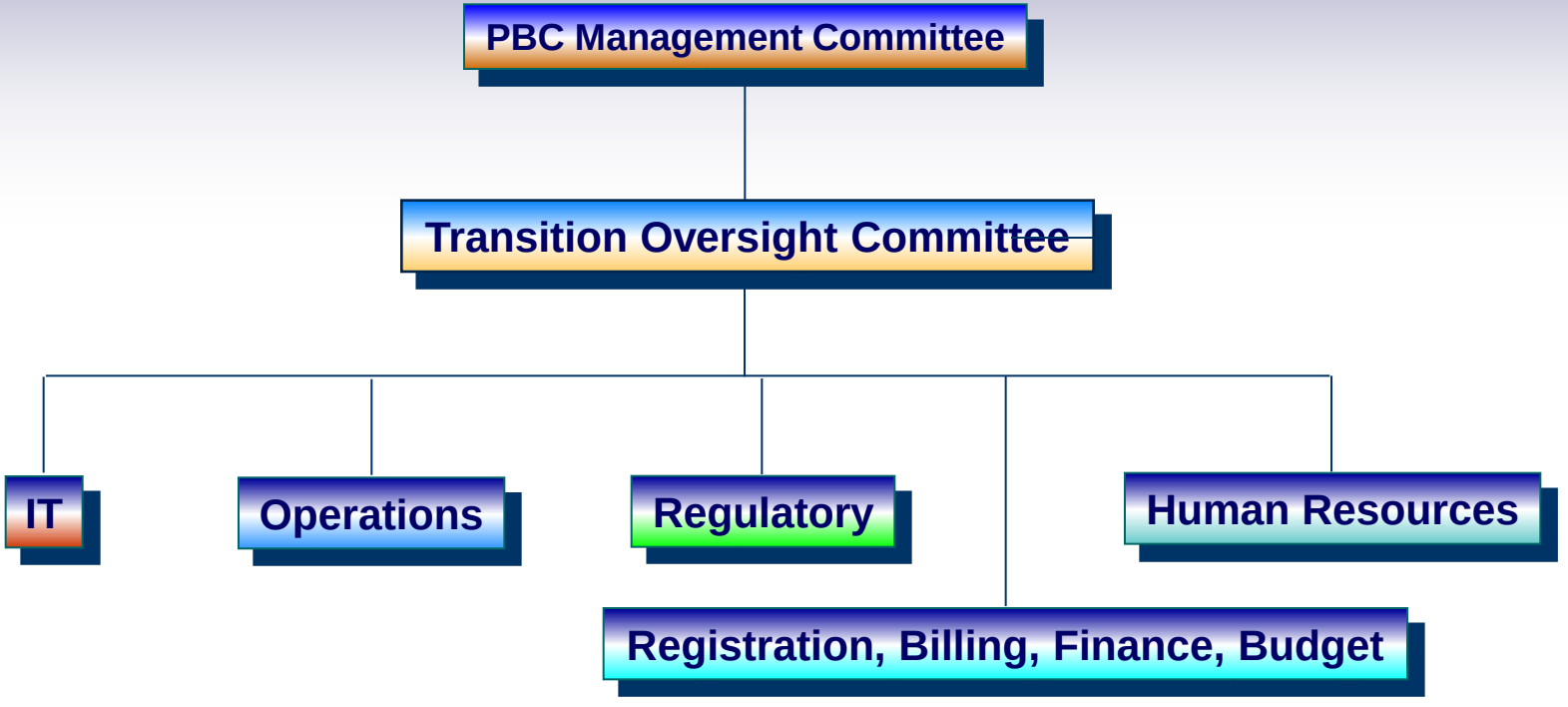
Organizing Implementation



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Data Requirements:

1. **Historical practice inpatient and outpatient CPT code (and wRVU) and payor specific volumes.**
2. **Physician FTE's.**
3. **Historical practice operating expenses (that would be assumed by the hospital to support the clinic).**
4. **Historical practice staffing (levels, compensation, benefits).**
5. **Hospital salary ranges and benefits for clinic staff.**
6. **Hospital pharmacy costs (where applicable).**
7. **Assumption about hospital overhead allocation.**

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Term sheet outline:

- Define the clinic scope of services.
- Compensation:
  - $'s/wRVU or other method, mechanism.
  - Medical directorships and management functions.
- Role, composition, size, scope of authority for the clinic management committee.
- Define medical directorship (s) and position descriptions.
- Define clinic management and responsibilities.
- Contract start date and term.
- Other key terms.

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Establishing compensation:

- Consistent with fair market value (FMV):
  - Cannot take into account the volume or value of anticipated referrals, hospital activity, etc.
  - Typically based on the wRVU method.
  - Reasonable compensation for a reasonable level of clinical productivity (e.g., if clinical productivity is at the median, then physicians can be paid the median compensation value per wRVU).
- More typical methods:
  - Fixed, one compensation rate/wRVU.
  - Tiered rate.

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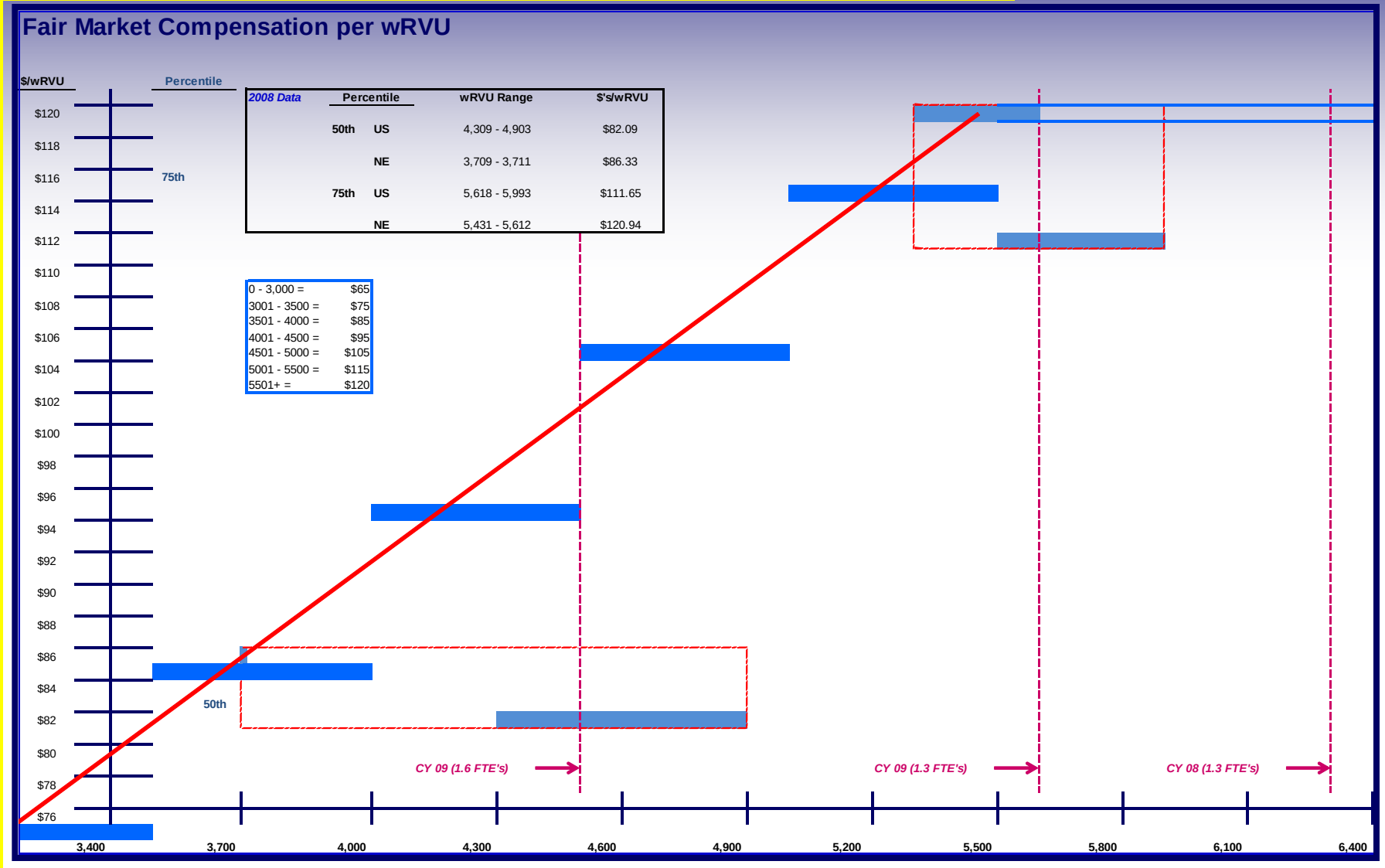
Fair Market Compensation per wRVU



2008 Data	Percentile		wRVU Range	$'s/wRVU
	50th	US	4,309 - 4,903	$82.09
		NE	3,709 - 3,711	$86.33
	75th	US	5,618 - 5,993	$111.65
		NE	5,431 - 5,612	$120.94

0 - 3,000 =	$65
3001 - 3500 =	$75
3501 - 4000 =	$85
4001 - 4500 =	$95
4501 - 5000 =	$105
5001 - 5500 =	$115
5501+ =	$120

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Comparative National Physicians Compensation and Production Data

MGMA 2008 - 2010 Private Practice National Data

	Percentile											
	Compensation				wRVU's				Compensation/wRVU's			
	25th	Median	75th	90th	25th	Median	75th	90th	25th	Median	75th	90th
Year	Hematology/Oncology											
2008		$363,428	$515,784	$777,783		4,903	5,993	7,302		$82.09	$111.65	$150.20
2009	$281,786	$373,037	$536,169	$778,709	3,405	4,569	6,192	8,008	$65.50	$84.90	$108.21	$137.00
2010	$277,886	$367,564	$522,247	$783,651	3,517	4,579	6,190	7,905	$66.26	$79.38	$103.25	$127.04
	Surgical Oncology											
2008		$331,250	$444,790	$544,353		6,630	9,765	13,891				
2009	$281,693	$305,520	$379,850	$447,042	4,704	6,318	8,421	9,929	$35.19	$45.43	$68.53	$82.44
2010	$260,230	$319,917	$469,873	$726,252	5,569	6,726	8,723	10,333	$37.87	$41.72	$55.67	$80.08

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Establishing compensation:

- Review historical worked wRVU and salary data:
  - Identify activities not credited towards compensation.
- Identify appropriate wRVU percentile:
  - Test the median – 75th percentile, unless compelling data to support otherwise.
- Establish compensation/wRVU at a level commensurate with clinical production percentile.
- Determine non-wRVU factors that are involved in the compensation mechanism.

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Establishing compensation (*example*):

- **Assume 3.5 FTE outpatient (office) hema/onc practice.**
- **Historical wRVU's = 4,300 – 4,700 per FTE (comparable to the median).**
- **Based on the practice's clinical production at the median, determine what the compensation is per wRVU at the median.**
- **Hema/onc PBC compensation per wRVU = $79.38.**
- **Medical directorship (s) are in addition to compensation for clinical production (~ $150/hour).**

Operational Considerations

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What are the key operational responsibilities to consider?

- **Clinic management committee (involved physician leaders and hospital representatives) meets monthly.**
- **Clinic must be fully integrated with hospital operations (operations, management, financial, IT, quality, etc.); Hospital assumes all clinic operating and management costs:**
  - **A detailed operational and implementation plan must be jointly developed by the parties.**

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What are the key operational responsibilities to consider?

- Clinic management:
  - Supervisor/manager required to manage the day to day operations of the clinic. Can be a hospital employee or contract with the practice or third party.
  - Practice management expertise within the hospital is also required. Can be a hospital employee, or contract with the practice or a third party.
  - Coding and billing performed by the practice or the hospital?
  - Cost of space for the clinic paid by the hospital (at FMV).
  - Hospital on site pharmacist required in many states.

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Where are the hospital bumps in the road?

- Do not value the practice as a strategic asset (and worse, purposely undervalue the asset believing the hospital has the leverage in the discussions).
- Lack of understanding about the model and how it works.
- Absence of a physician relationship strategy.
- CEO or COO not engaged in the process (i.e., courtship).
- Resistance to change.
- Lack of understanding about “1500” professional billing.

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Where are the practice bumps in the road?

- Do not understand or accept the fair market value framework.
- Loss of control is not acceptable.
- Line in the sand drawn on specific economic or control issues to favor the practice (often based on a misperception that the practice controls the leverage in the discussions).
- Inability of practice discussion leaders to bring the group along.
- Perception that the provider based clinic model minimizes the attractiveness of the group as a private practice.
- Inaccurate and irreversible physician perceptions.

Summary

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Summary:

- **Requirements:**
  - **Expertise with wRVU based compensation plans.**
  - **As a distinct competency, a physician practice management organization within the healthcare system.**
  - **Healthcare business legal counsel participation to guide the discussions and review the assessments and analyses.**
  - **Use an unbiased, objective third party facilitator (discipline for the planning process and discussions, establishes the trust bridge, subject matter expert).**

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Summary (continued):

- **Accurately complete the due diligence:**
  - **Thorough review of historical practice activity levels, business practices, and payor specific CPT code mix and wRVU levels.**
- **Reality: 80% - 90%+ of the discussion focuses on economics and control.**
- **Do you best to keep the physicians engaged and understand the FMV methodology behind the economics, and the overall process to link salary with clinical production.**

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Summary (continued):

- **Management and medical directorship responsibilities are compensated at a FMV level and are in addition to clinical production compensation.**
- **Credibility and transparency in the discussions leads to building trust between the parties and longer term in the relationship:**
  - **Trust can be easily eroded with the slightest indiscretions, even if inadvertent.**

Questions and Answers

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- **Why would a hospital want to develop a provider based clinic model with physician practice?**
  - ***Typically, the practice under consideration is vital to one of the hospital's clinical programs. The model provides the practice with one option to consider given the changing environment that affects yields on income based on historic income generating mechanisms for physicians.***
  - ***The model creates a platform for income and goal alignment between the practice and the hospital, while preserving and respecting the practice's private practice structure.***
  - ***The model serves as a direct strategy (that does not currently exist) for clinical integration among clinical programs.***

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- **Why should a practice consider this model?**
  - ***First, there is little risk in discussing it with the hospital. Second, the practice can consider the model if leadership believes practice income will continue to come under attack.***
- **We worked hard to establish and expand the practice. Why shouldn't hospital recognize the value of the practice and pay for such?**
  - ***The provider based clinic model is not an asset transaction and does not involve purchasing the practice. It is a contractual based arrangement (professional services contract between the practice and the hospital) and requires a business structure (i.e., private practice) for the physicians to contract with the hospital.***

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- **Why should we just hand over the practice operations to the hospital?**
  - ***Under a PBC arrangement, the practice continues to maintain full control of the practice and to have a significant role in operations. By maintaining the private practice structure, the practice contracts with the hospital to transition one (or more) of its practice sites to a provider based clinic arrangement. Under the proposed PBC structure, the practice would have a significant role in the operations and control of the clinic. Further, if the practice's operations become a provider based clinic, the hospital's and the practice's infusion therapy services can be combined.***

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- **Is this the only model available for physicians to consider as an option to more closely align with hospitals and/or to achieve improved practice economic stability?**
  - ***No, there is a limited set of other models, including employment, cancer program co-management, and merger with another group. Over time the list has fewer options, the provider based clinic model is probably a better fit than others, and it has potentially greater longevity than others.***
- **Can the practice implement this model with more than one hospital (simultaneously)?**
  - ***Yes, each professional services contract is negotiated separately and is unique to the specific hospital business relationship*.**

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- **If the practice implements this model, do the physicians become hospital employees?**
  - ***No, the practice's private practice status remains through a professional services agreement (contract) with hospital*.**
- **Does the practice's employees have to become hospital employees under the PBC model?**
  - ***Under the model and the CMS requirements, clinical (non-physician) staff who do not have the option to bill under Medicare (non-AP nurses, tech's, etc.) have to be W-2 employees of the hospital. Non-clinical staff required for the operations can be hospital employees or the hospital can contract for the staff (e.g., lease from the practice).***

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- **What if the practice or the hospital decides the model does not work after it is implemented?**
  - ***Either party can elect to terminate the contract/PSA. An adequate termination period should be planned in the professional services contract as a contingency. Unwinding the model would require the practice to access space (another contingency that can be incorporated into the PSA) and hire staff.***
- **How is "balance" maintained (with respect to control and the economics) in the model?**
  - ***First, the management committee serves as the "board" for the model. It should meet at least monthly and have an agenda focused on the business relationship, financial performance, growth, and integration. Second, the term of the contract can be limited (e.g., one or two years) to provide incentive to both parties to focus on balance in the relationship.***

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- **How does the practice retain control if its name, image, and indentify if the model is implemented?**
  - ***Since the PSA is a contract between the private practice and the hospital, the practice will continue to retain control over the practice, its image, and its name. It is in the interest of both the practice and the hospital to strategically leverage the name and image of both organizations in the model*.**
- **Can the hospital provide the practice with a long term compensation guarantee?**
  - ***No, the model must remain compliant with state and federal statutes and regulations, and using fair market value principles to establish compensation terms. Compensation arrangements with a provider based clinic model are typically structured around wRVU's. Since the national data lags 1 – 2 years behind the market data, the model does provide some potential benefit to physicians.***

Structuring the Contract

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Contract outline:

- Description of employment responsibilities and duties.
- License, qualifications, medical staff membership, certifications.
- Rules, regulations, disclosures (insurance claims, conflicts of interest, criminal charges or investigations, etc.).
- Compensation (amount, method, payment mechanism and terms).

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Contract outline (continued):

- Term and termination.
- Restrictive covenants.
- Effect of legal changes.
- Severability
- Other standard legal components (applicable laws, assignment, successor, authority to commit, notices, etc.).

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Contract outline (continued):

- **Key attachments to include:**
  - **Medical director position description.**
  - **Schedule of clinic management responsibilities to be performed by the practice.**
  - **Role, composition, size, scope of responsibilities, authority, and function of the management committee.**
  - **Detailed description of the compensation plan, compensation $'s per wRVU, calculation and payment mechanisms detailed with examples provided.**