2017 Cancer Center Business Summit

Transforming the Business of Oncology through Science and Technology
Integrated Practice-hospital Affiliations

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Integrated Practice-Hospital Affiliations: Structural and Legal Considerations

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Oncology Practice-Hospital Alignment

• Recent Developments Driving Alignment
  – MACRA and Cures Act, including site neutrality rules
  – OCM
  – Proposed 340B Omnibus Guidance
  – Change in Administration/Uncertainty

• Principal Structural Options
  – Employment/Practice Acquisition
  – Professional Service Agreements
  – Clinical Co-Management Arrangements
  – Radiation Oncology/Equipment Joint Ventures
  – Bundled Payment/Episode of Care Programs
  – Accountable Care Organizations/CINs
PSA STAFFING/CONVERSION AGREEMENTS
PSAs: Introduction

• Potentially Powerful Tool
  – To staff existing hospital oncology service line or develop new cancer center
  – To convert existing oncology group sites to hospital licensed facilities paid at hospital outpatient payment rates (by some payers)
  – Integrate and align hospital and group to improve quality, efficiency, and operations of hospital’s oncology service line, while maintaining a modicum of group’s independence
PSAs: Introduction (cont.)

• Potential economic win-win
  – Group paid fair market value compensation on an aggregate fixed fee or work relative value unit ("wRVU") basis
    • Eliminates risk of reimbursement reductions (e.g., MACRA and OCM downside risk) and collection risk (free care/bad debt)
    • Other: additional payments for purchase of equipment, management services, billing services, co-management services?
PSAs: Introduction (cont.)

- Hospital converts group sites to hospital satellite sites or develops new cancer center: captures new book of oncology business
  
  • Good contribution margin due to combination of hospital rates and physician office cost structure, but limited by new Medicare site of service neutrality rules
    
    - Medicare physician fee schedule rates for new off-campus facilities after 1/1/17, with certain exceptions
    
    - Medicare outpatient payment rates continue for
      
      » on-campus facilities
      
      » “grandfathered” off-campus facilities (attested prior to 11/2/15)
      
      » “mid-build” facilities (with written agreement by 11/2/15 and attested by 2/13/17)
      
      » Cancer hospitals (attested within 60 days of meeting PBS)
PSAs: Introduction (cont.)

• 340B Program — Potential 340B pricing opportunity, but may be rolled-back by final Omnibus Guidance
• Proposed Omnibus Program Guidance by HRSA (RIN 0906-AB08) issued 8/28/15
  – Controversial: Pharma and some independent oncology groups v. Hospitals
  – Hospital must bill for the professional component of the service as a hospital outpatient service; it does not appear that a hospital-owned or affiliated group could bill for the service
    • May be prohibited by CPOM constraints in some states
  – Infusion visit-only drugs not covered
  – Discharge drugs not covered
  – Drugs in Medicaid bundle not covered
  – Uncertain timeline for final guidance
PSAs: Introduction (cont.)

– Potential economic losers
  • Payors — higher rates for “same” services
  • Patients -- Higher/double patient co-pays
  • Pharma -- Erode pharma profitability by extension of 340B
Professional Services Agreement

Hospital provides:
- License
- Provider-based status
- 340B pricing

Professional Services Agreement

Payors

Oncology Sites/Service Line

$/wRVU

Oncology Group

Group provides:
- Physician/NP/PA staffing
PSA Transaction

- Avoid U/A transaction — Group cannot “perform the service”
  - Hospital could take assignment of Group leases from landlords
  - Hospital could purchase Group’s FFE and inventory at fair market value
  - Hospital would need to employ nurses/techs at off-campus locations (to meet Medicare provider-based status rules)
- Group can provide all other staff
  - Physicians/NPs/PAs
  - Non-clinical staff at all sites
  - Nurses and techs at on-campus sites
PSA Transaction

• Potential Transactional Elements
  – Professional Services Agreement (PSA)
  – Asset Purchase Agreement (APA)
  – Management Services Agreement (MSA)
  – Co-Management Agreement (CMA)?
Professional Services Agreement

Hospital provides:
- License
- Provider-based status
- 340B pricing
- Space/equipment
- Nurses/techs (off-campus)

Group provides:
- Physicians/NPs/PAs
- Non-clinical staff
- Nurses/techs (on-campus)
- Administrative services?

Notes:
- FMV for assets and Group retains cash and A/R
- PSA on fair market wRVU or fixed compensation basis
- MSA on a cost plus fair market mark-up or fixed fee basis
- Billing services at fair market percentage of collections or fixed fee per claim?
Key Deal Maker/Breaker Issues

- Governance
- Financial Terms
- Performance Standards
- IT Integration
- Staffing Plan and Addition of New Physicians
- Site Improvements/Capital Expenses
- Term and Termination
- “Platform” Transaction/ROFOs
- Restrictive Covenants
- Unwind Rights
- Arbitration/Dispute Resolution Process
Other PSA Considerations

• Impact on OCM participants — CMS discretion to amend participation agreement
• Will commercial payers adopt site of service payment neutrality?
• Harmonizing PSA compensation method with new shared savings, bundled payment, capitation and risk based payments
• Heightened Stark Law scrutiny of physician compensation arrangements, including under PSA agreements
Other PSA Considerations (cont.)

• Duration/durability: periodic revaluation and reset of performance metrics
• Employment: unions and split staff (off-campus) and salary/benefit differentials
• Change of administration or ownership
What Is a Service Line Co-Management Arrangement?

- PSA purchases professional services of physicians and clinicians
- MSA purchases support services of non-clinical staff
- Co-Management Agreement purchases medico-administrative services from physicians and clinicians
- Engage oncologists as a business partner in managing, overseeing, and improving service line quality and efficiency
  - No overlap in contractual duties between PSA and Co-Management Agreement (or other agreements)
Service Line Co-Management Direct Contract Model

- **Payors**
- **Hospital**
  - **Service Line**
    - Hospital-licensed services
  - **Operating Committee**
    - Designees
    - \$ Co-Management Agreement
      - Two, or multi-party contract
      - Specifically enumerated services
      - Allocates effort and reward between groups
- **Oncology Group I**
- **Oncology Group II**
- **Other Group(s)**

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Service Line Co-Management Joint Venture Model

- Payors
- Hospital
- Oncologists/Groups
- JV Management Company
- Service Line

- Capital Contributions
- Profit Distribution
- Co-Management Agreement
Comparative Structural Considerations

- Direct contract model is simpler and less expense
- JV model better reflective of relative roles/responsibilities of hospital/MDs?
- JV Model permits structuring outside of Stark Law
- Potential securities offering for JV model
- Direct contract more remunerative?
- Participating MDs performing disproportionate services/compensation based on relative efforts v. invested capital?
- Physician holding company?
Service Line Co-Management Arrangements

- Typically two levels of payment to physician managers:
  - **Base fee** – a fixed annual base fee that is consistent with the fair market value of the time and effort participating physicians dedicate to service line development, management, and oversight
  - **Bonus fee** – a series of pre-determined payment amounts, each of which is contingent on achievement of specified, mutually agreed, objectively measurable, program development, quality improvement, and efficiency goals
Service Line Co-Management Arrangements (cont.)

– Aggregate payment generally approximates 1.5-3% of service line revenues
  • Expressed as fixed, fair market value compensation; independent appraisal strongly advised
Additional Legal Considerations

There are legal constraints on Service Line Co-Management Agreements (*i.e.*, CMP, AKS and Stark):

- No stinting on medically necessary care
- No steering
- No cherry-picking
- No gaming
- No payment for changes in volume/referrals
- No payment for quicker-sicker discharge
- No reward for changes in payor mix, case mix
- Must be FMV; independent appraisal required
Additional Legal Considerations

• Adv. Op. 12-22 approving co-management arrangement
• Some irreducible legal risk because aggregate compensation is not set in advance
• Minimize legal risk by:
  – Compliant contract and performance standards
  – Independent FMV appraisal
  – Internal or external monitoring
  – Good documentation
  – Good execution
RT JOINT VENTURES
RT Facility (Provider) Joint Venture

- Hospital contributes certain space, equipment, and staff
- RO Group contributes certain space, equipment, and staff
- Separately licensed RT service (in some states)

**Notes** (NB: Provider JV only for RO Groups based on Stark Law “consultation exception” for ROs)

- New license and/or CoN for RT Facility needed in some states
  - License as free-standing clinic, IDTF/Radiation Therapy Center paid at physician office rates
- Technical component of RT services provided under license and billed under provider numbers of free-standing RT facility
- Professional component of RT services provided and billed under Oncology Group provider numbers
- Owners share profit/losses from technical component operations
RT Technical ManageCo Joint Venture

**Notes**
- Technical component of RT services provided by ManageCo to Oncology Group
- Professional and technical components of RT services billed under provider numbers of Oncology Group on IOASE basis
- Management fee on fixed fair market value or percentage of revenue basis (subject to a FMV cap)
- Owners share profit/losses from technical component operations
- Challenges include structuring license of tax exempt bond financed hospital space to comply with “private use” restrictions; physical separation of Oncology Group services within Hospital space; and arrangements to support inpatient services
Integrated Practice-Hospital Affiliations: The West Clinic Case Study

Presented by:
Lee Schwartzberg, M.D.
Senior Partner and Medical Director
The West Clinic
West Cancer Center Update

February 6, 2017
Lee Schwartzberg MD, FACP
Executive Director, West Cancer Center
The Beginning

• Strategy discussion in 2010 regarding future state of practice
  – Grow organically
  – Merge local practices
  – Partner with national organization
• Practice was healthy, growing and receiving good reimbursement
• RFP sent out to regional systems January 2011
Partnership Negotiation

• Proposal accepted from Methodist Health System
• Growing relationship with U of Tennessee Health Science Center/new Dean of College of Medicine
• Cancer center concept took hold
• Negotiated PSA agreement and co-management agreement
Details of the Partnership

PSA agreement

• PSA agreement
  – West Clinic contracted with MHC to provide all med/gyn onc services
  – FMV RVU multiplier based on 2011 numbers
  – 340B pricing to allow insurance neutrality to RVU revenue
  – Kept West Clinic 3\textsuperscript{rd} party contracts-did not move to hospital provider based billing model
  – Non-Physician Clinical staff became hospital employees
  – Assets purchased
  – Several satellite sites continued as independent WC operations
Details of the partnership

Co-management agreement

• 3rd party assessment of value and initial CMA goals
• 8-10 goals selected/year, at least half with qualitative/quantitative goals to meet for reimbursement
• Change every year with mutual consent from WC and MHC
Details of the Partnership

Executive Cancer Council

- 13 members, 4 from each partner WC, MHC, UTHSC + Executive Director
- Responsible for strategic vision, recruitment and management of the LIFT money (margin committed contractually to cancer center development)
2012: A Partnership between West Clinic, Methodist LeBonheur Healthcare & the University of Tennessee Health Science Center
ACCOMPLISHMENTS TO DATE

PATIENT CARE

– Increased access to underserved and/or minority populations
  • Indigent percentage 4x since 2012 (~2.5% to ~10%)
– Develop quality initiatives, navigator, survivorship programs
– Developed community based disparity programs and outreach
– Develop multidisciplinary disease oriented care teams and patient services

FACULTY RECRUITMENT

– Radiation oncologists, bone marrow transplant, surgical oncology, breast surgeons
ACCOMPLISHMENTS TO DATE

RESEARCH

• Clinical Research
  – Leaders in Phase I and overall clinical research

• Translational Research
  – Physician scientists and PhDs

EDUCATION

  – Medical Oncology Fellowship-now 15
  – Rad Onc residency
  – Gyn Onc fellowship, Surg Onc and Breast Surg Onc pending
UT/West Institute For Cancer Research

501 (c) 3 Founded 2014

- All philanthropy directed to the institute
- Vehicle to distribute seed funding to scientists
- Used to enhance non-reimbursable programs (disparity screening, nutrition, integrative medicine, etc.)
WEST Cancer Center: Germantown
Opened December 7, 2015

• 135,000 Square Feet

• Breast Center, Medical Oncology, Surgical Oncology, Gyn Oncology, Radiation Oncology, Phase 1-3 Research, Diagnostic and Interventional Radiology, Infusion Center
West Cancer Center

People

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## West Cancer Center

### West Clinic Physician Growth

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</table>
## West Cancer Center

### Cancer Center Site Growth

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<td>2015</td>
<td>12</td>
</tr>
<tr>
<td>2016</td>
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New Negotiations

Began in 2015, year 4 of 7 year contract

• Hired Consultant Firm
• Multiple meetings over a year
• Several different concepts addressed
  – Stay as is
  – Employment (Foundation) model
  – “Friendly PC” model
• Still in process, LOI signed among the three parties
Agreed upon concepts for new model

• All-in by each group
  – Comprehensive service line by MHC, board representation
  – Integration of all sites by WC, moving away from shareholder model
  – Practice plan transfer by UTHSC

• Physicians retain control
  – Voting members of New PC are all physicians (TN law)
  – Silos retain authority for reimbursement distribution
  – CEO of WC becomes CEO of new PC

• Cancer council is same board with non-physicians added as voting members

• Vision is NCI designation in 5-7 years
What do we give and get?

• Give
  – Some authority and some decision making
  – Unwind
  – Shareholder mentality
  – Satellite sites

• Get
  – Larger platform to provide value based health care
  – Payer leverage
  – Capital funding for growth (centers, clinicians, scientists)
  – Protection against fundamental shifts in reimbursement
  – Ability to realize the cancer center dream
Integrated Practice-Hospital Affiliations: HonorHealth Case Study

Presented by:
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Oncology Practice-Hospital Alignment

• Why partner?
  – Enhancing patient experience through the creation of a clinically integrated oncology network/OMH
  – Strengthen our community Health System’s market presence addressing:
    • tertiary-level market competition
    • savvy healthcare consumer demands of cohesive, coordinated, data-driven, oncology care services
  – Integration and natural extension of other specialty services
  – Position for value-based payment models
Oncology Practice-Hospital Alignment

• Step 1: Picking the Right Partner
  – Hospital System
    • Understand health system’s oncology market position
    • Must have clear direction and commitment to oncology
    • Aligned vision for the future of oncology
    • Clear understanding of “the why” across C-suite
    • Financial stability and sustainability
  – Physician Partners
    • Clear and high functioning leadership structure
    • Global vision with eye on the future
    • Collaborative win-win culture
    • Desire/directionally moving towards APMs
    • Financial stability and sustainably
HonorHealth and the Scottsdale/Phoenix Market

• **HonorHealth:**
  - 5 hospital network in Northwest and Northeast Valley
    • 2 ACoS CoC Accredited Programs
    • 1 NAPBC
  - 1200 beds
  - Freestanding OP Cancer Center
    • Essentially an MOB for community oncologist
  - Extensive surgical and procedural specialist
  - Extensive clinical research with 30+ Phase 1 clinical research trials
  - 325 Primary Care Physicians and 20 Gastroenterologist
  - BMT/Acute Leukemia
  - Strong relationship with specialist including community Urologist, plastic/Reconstructive Surgeons
  - Hospitals work inclusively with all groups but struggle to create unified programs, COE’s, Quality Programs, or Pathways
HonorHealth and the Scottsdale/Phoenix Market

- Medical/Radiation Oncology in Phoenix Valley
  - 4 independent medical and radiation oncology groups across the valley
  - All groups aligned with multiple hospitals
  - All groups w/ extensive investment in facilities, imaging, radiation oncology, dispensing pharmacy, lab and research services
  - Relationship: Highly competitive, aggressive recruitment of breast surgeons, GYN oncologists and urologists
Initiating the conversation

• January 2014: Held oncology forum for all community physicians with “interest” in oncology
  – 130 physicians attended
  – Advisory Board: National trends in physician-hospital alignment
  – Hospital: Vision for providing comprehensive oncology care in a highly coordinated care
    • Repeatedly stated we are looking to identify community partners

• Feb-March 2014:
  – Engaged Oncology Solutions, LLC to educate C-suite, facilitate discussions and provide due diligence
  – Individual meetings with 4 community oncology groups
  – Discussed their vision and interest in partnerships
Designing the Alignment

• Based on individual interviews with the four groups, two preferred partner(s) were chosen for further exploration
• Strong relationships existed with each group
• BMT program in partnership with USON Group
• Continued conversations highlighted overwhelming challenges with aligning with one of the two groups
• Alignment with large Community Oncology Group advanced “rapidly”.

The Value Equation

• Hospital:
  – Access to high quality medical, GYN and radiation oncology providers for our network of physicians
  – Joint operating and governance structure including significant physician participation and C-suite collaboration
  – Partner in developing/implementing defined oncology program (Standards, Pathways, and Quality)
  – Partner to participate in new payer contracts.

• Oncology Practice
  – Clinical integration with Hospital medical group 325 primary care physicians, gastroenterology practices and strong alignments with independent specialists and surgical practices
  – Alignment with Health System EHR/EPIC
  – Positioned for oncology alternate payment models inclusive of the entire cancer care continuum
  – Marketability
HonorHealth-AZCCC Alignment

• AZCCC Professional Practice Remains Intact
  – PSA with HonorHealth for Med Onc/GYN Onc
  – Excludes Urologist and Breast Surgeons

• HonorHealth Acquired
  – 8 Medical and GYN Oncology Sites
  – Infusion Pharmacy
  – Lab
  – Clinical Research (Phase 2 & 3)
  – Retail Pharmacy
  – Minority interest in Practice’s Radiation Therapy business
HonorHealth-AZCCC Alignment

- **Management Services Agreement**
  - Scheduling, registration, insurance verification and authorization, billing/coding through clean claim
  - Day-to-day operational support
  - Practice executive leadership support

- **Clinical Co-Management Agreement**
  - 60% performance-based payment for 10 highly aggressive performance goals
  - 40% administrative services payment/physician and staff time-based payment
Initial Challenges

- Commanding attention of HonorHealth Executive team in wake of recently completed system merger
- Educating C-suite of oncology industry trends and emerging oncology payment models, OCM, etc.
- Convincing hospital to engage Valuation Company specializing in oncology
  - Unlike any other health system physician transaction completed
  - Traditional valuation firm used by Health System lacked oncology expertise
  - Oncology REALLY is different
- Merging EHRs and timing
  - Hospital just launched Epic
  - AZCCC just transition from Varian Aria to OncoEMR
- Co-Management
  - Maintaining hospital’s relationship with Medical Directors in “competing” groups
Initial Challenges

• Don’t underestimate the capital requirements to convert OTCs to hospital standards
• Branding and Marketing: Freedom in private practices vs. being more prescriptive in Health Systems
• Managing the sheer number of moving parts and seeking/managing too many approval avenues
• Educating Health System in-house legal and finance regarding the potential of the deal
• Educating C-suite the deal was not a 340B “play”
What came together well

• Cultural match and shared vision
• Commitment to shared governance and operating model; Agreement to manage as single oncology service line
• Health System and AZCCC partnership, commitment and responsiveness to implementation activities/Task Force infrastructure
• Commitment of Health System Foundation
• Facility renovations and new construction
What had to change for Practice Norms

• All clinical staff to become hospital employees
• Site state licensing!
  – w/o down-time
• Pharmacy vs. Mixing Area w/ State Board of Pharm
  – USP 797/800
• Payer contracting!
• Policies and procedures better defined and adopted
  – Port Access
• Initially will have OncoEMR as clinical chart and Epic for billing
  – Some double entry for 1st 4 months
• Insurance verification
What had to change for Practice Norms (cont’d)

• All new chemo chairs, guest chair, waiting room furniture
• Small things matter!
  – Vendor contracting
    • Cleaning, supplies, copiers, linen, etc.
• IT Support
  • OncoEMR is cloud based = EASY
  • Phone systems
  • IT Infrastructure
Integrated Practice-Hospital Affiliations: Radiation Therapy Joint Venture Case Study

Presented by:
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Radiation Therapy Joint Venture

An Integrated Practice/Hospital Affiliation
Presented by: Warren L. Benincosa, CEO
Cancer Care Northwest, P.S.
Warren.benincosa@ccnw.net
509-228-1010
A Little Background

- Long standing practice est. 1975
- Grew from 2 Medical Oncologists to 12.
- Added Radiation Oncology
- Joined USON in the 80s
- Added Surgical Oncology
- Bought ourselves back in 2008
- Grew to 40 providers
- > 65% Market Share
Market/Environment

- Service Area was entire East side of the state of WA, Northern Idaho and Western Montana.
- Hospitals were purchasing practices and expanding services.
- Everyone was building another radiation vault.
- We wanted to remain independent.
- We felt we needed a tertiary partner to continue to grow into the regional oncology presence we wanted to become.
- We approached the largest hospital system in our area and asked them to join with us.
Linac Arms Race

Pre-Alliance
CCNW – 4
WA Hos - 3
ID Hos – 2
Other – 1
Planned – 3
Total of 13

Post-Alliance
CCNW – 7
WA Hos - 1
ID Hos – 0
Other – 2
Planned – 0
Total of 10
And so it Began. . .

- Went to Providence, they said yes.
- We wanted to expand in Northern Idaho.
- Kootenai Health said they wanted in. . .
- The Alliance was born.
It Takes Time, be Patient

• Hardest part was waiting. . .
• It took a full year to get the paperwork complete it is pretty complicated.
The Paperwork

- Confidentiality
- Stand Still/Non compete
- Formation of the alliance
- Licensure
- CMS and Insurers
- Employee Leasing
- Inpatient Contracts
- Trademark and Copy write

- Space Leasing
- Equipment Leasing
- Valuations to establish FMV
- PSAs
- Management contracts
- Special needs;
  - Tax Exempt Bonds
  - Private Use restrictions
It Takes Time, be Patient

- Hardest part was waiting. . .
- It took a full year to get the paperwork complete it is pretty complicated.
- CCNW retained employment of those “pushing the button.”
- All others became employees of the Alliance.
- In the beginning all employees had a job.
- But we all knew, going into this, everyone had to give up something to create efficiency.
What we ended up with

- CCNW is the largest member of the LLC (but < 50%).
- CCNW is the managing partner.
- Alliance board that consists of two members from each entity. We meet at least quarterly.
- Medical Director is an RO from CCNW
- Certain decisions require consent of CCNW
  - New sites
  - Debt
  - Major capital
Alliance Illustrated
Benefits

• Patients receiving the same high quality care regardless of location.
• Fewer Linacs operating closer to capacity (more efficient and more profitable).
• CCNW experienced increase in surgical, medical referrals
• We have set the tone for other ventures and programs that we can do together.