2011 Cancer Center Business Summit

Achieving Accountable Cancer Care

October 13 – 14, 2011

Palmer House Hotel • Chicago, Illinois

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Compensation Models to Align Hospital & Oncologist Interests

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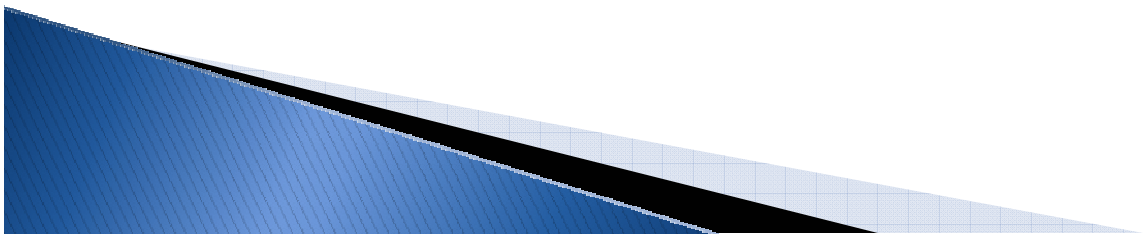
Compensation Models to Align Hospital & Oncologist Interests

Panelists

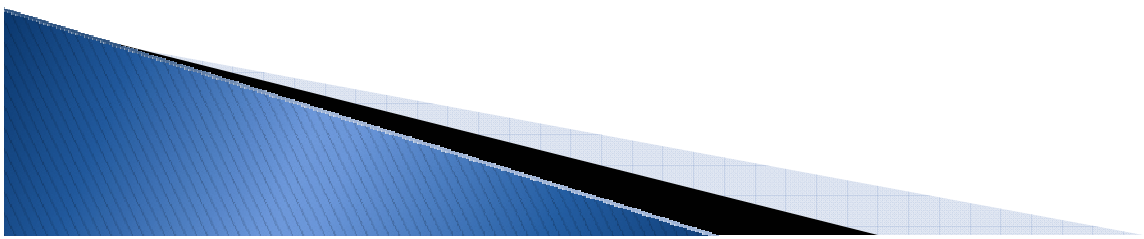
- Ronald Barkley, MS, JD, Managing Director, CCBD Group
- Teri Guidi, MBA, President & CEO, Oncology Management Consulting Group
- Jennifer Johnson, CFA, Partner VMG Health



Compensation Models to Align Hospital & Oncologist Interests

Topics

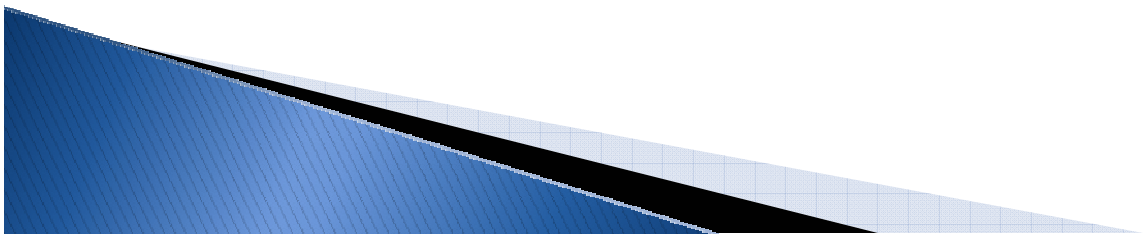
- Compensation for medical professional services (patient care)
- Compensation for medical supervision - medical advisory services (medical direction)
- Compensation for management services
- Valuation issues pertinent to the above
- Valuation issues pertinent to valuing quality



As a Point of Reference
PSA/Co-Management
Case Study of Preceding Breakout Session

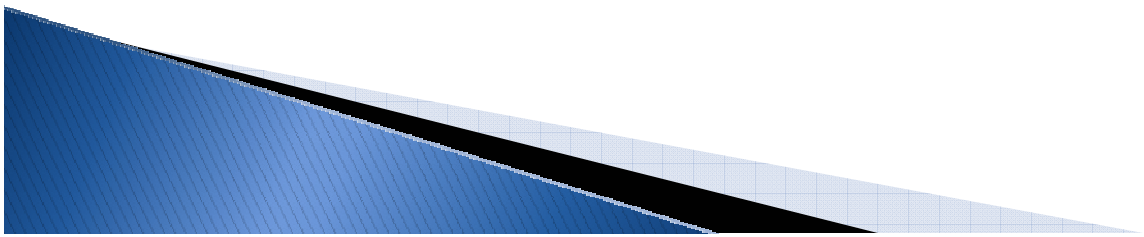
Medical Oncology practice to provide:

1. Professional medical staffing at 3 hospital sites;
2. Clinical oversight and admin co-management of all outpatient hem/onc services;
3. Medical directorship;
4. Clinical research program oversight;
5. Billing & collections (revenue cycle);
6. Service line staffing.



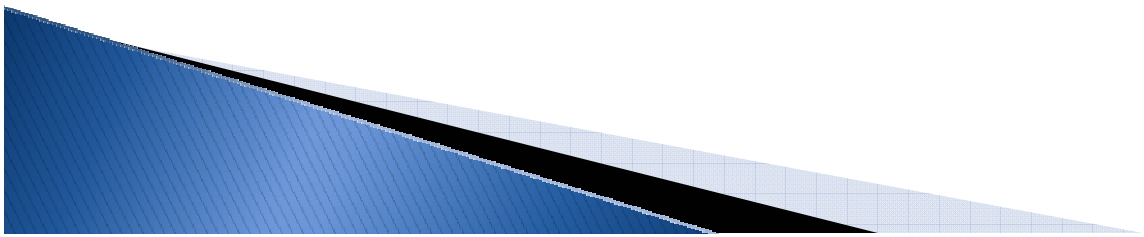
Professional Service Agreements

- Physicians retain the practice entity (tax ID) and thus remain independent of the hospital
- The hospital contracts with physicians to provide professional medical services to patients
  - Evaluation & Management
    - In patient encounters
    - Out patient encounters
    - Other encounters
  - Other professional services
    - The professional component of procedures (e.g., bone marrow biopsy – modifier -26 codes)



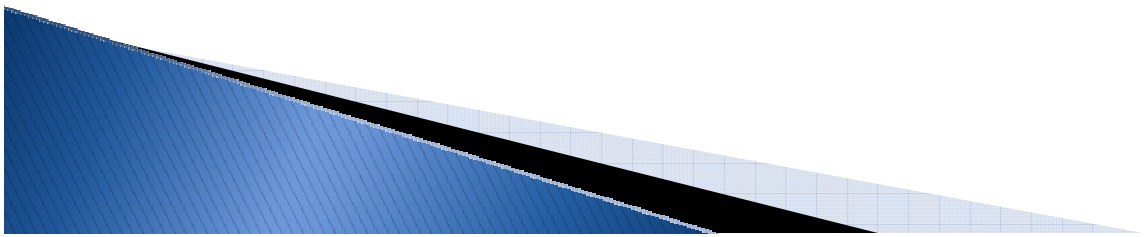
Professional Service Agreements

- The hospital negotiates payment with the physicians for those services
  - Generally a fee schedule per CPT code
  - Payment at “fair market value”
- The hospital negotiates rates for professional services with payers
- The hospital bills payers for professional services (on a CMS 1500) and collects reimbursements



The wRVU Conundrum in Oncology

- Value is often tied to survey data
- Survey data frequently aggregates wRVU for E&M with wRVU for procedures including chemotherapy administration
- PSA does not include administration of chemo
- Therefore, adjustments may be necessary to ensure appropriate fee schedule or “salary”



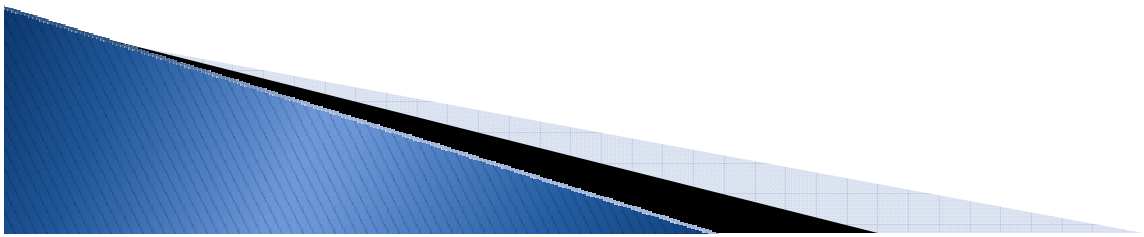
The wRVU Conundrum in Oncology

Work Relative Value Units may account for 12%-13% of total Work Relative Value Units

Category	MD #1	MD #2	MD #3	Total
Chemo Admin RVUs	815	925	950	2,690
E&M RVUs	5,775	6,610	7,050	18,485
Totals	6,590	7,535	7,050	21,175
Chemo Admin RVUs as % total	12.4%	12.3%	13.5%	12.7%

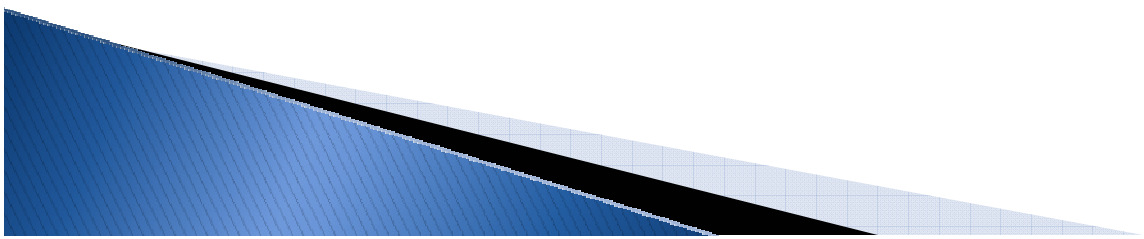
Co-Management Agreements

- Hospital and physicians enter into an agreement where physicians are jointly responsible with hospital for managing a defined service line
  - Definition can vary and will depend on legal counsel review for appropriateness
- Hospital (usually) pays physicians a fixed base rate plus performance-based “bonus”
- Performance may ***not*** be tied to service volumes, charges, or revenue



Co-Management Agreements

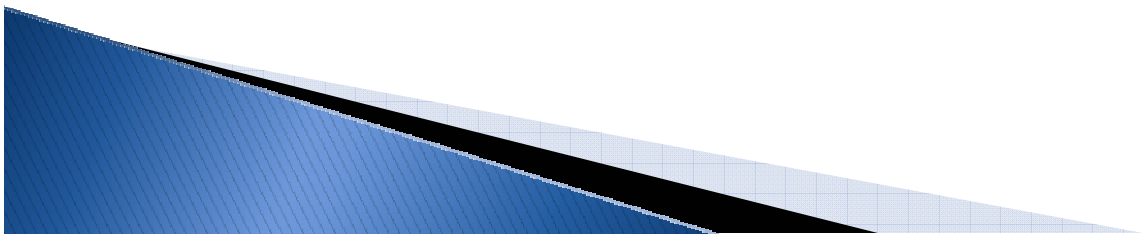
- Base compensation covers the management of the service line. For example:
  - Oversight of operations
  - Leadership
  - Development/implementation of strategy



Co-Management Agreements

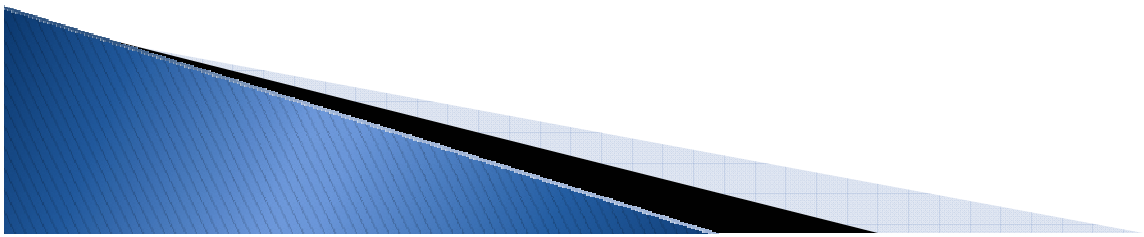
- Performance incentives reward leadership of the service line to specified targets or goals.

  For example:
  - Overall growth of the program
  - Percentage improvement
    - Operational efficiencies
    - Budget performance
    - Quality indicators



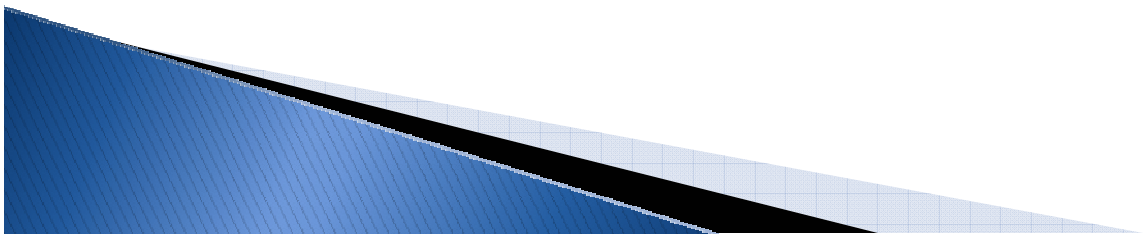
Medical Directorship

- Payment may be a stipend or other arrangement
- There must be a means of “justifying” the payment
  - Defined duties
  - Time and effort expended
- The duties must not duplicate other arrangements
- Incentives are possible but rare



Clinical Research Oversight

- Similar to Medical Directorship
  - Stipend or other structure
  - Defined duties
  - Time and effort expended
  - Duties must not duplicate with others
  - Incentives?

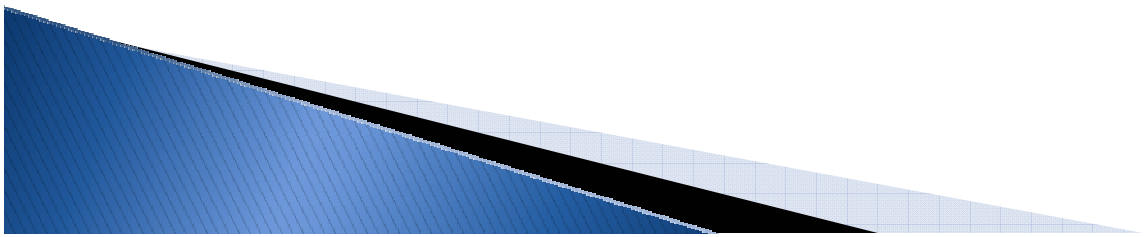


Management Services Approaches to Hospital Service Line Relationships

- Service line staff leasing
- Service line billing & collections
- Manage provider-based infusion service or indigent clinic

Service Line Staff Leasing

- Practice has the experienced staff to operate outpatient oncology services
- Hospital could benefit from this staff to operate the hospital service line
- Disruptive to terminate and re-employ staff
- Instead, hospital leases the staff from practice, typically payroll cost plus formula
- Clinical staff (nurses) employed by hospital in off campus provider-based scenario

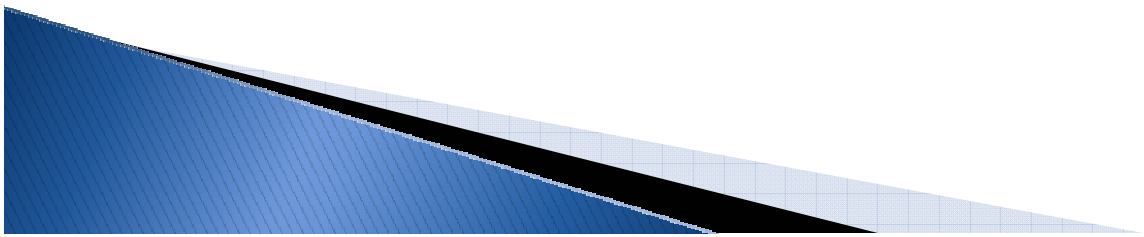


Service Line Billing & Collections

- Oncology billing & collections – particularly drug – is complicated!
- Practice has the expertise in oncology-specific billing & collections
- Hospital could benefit from this expertise in performing service line outpatient oncology billing
- Hospital enters into billing & collections contract with practice
- IT/billing system integration is problematic

Manage Provider-based Infusion Service or Indigent Clinic

- Practice contracts with hospital to manage hospital infusion service or indigent clinic for a fee;
- Applicable within or outside context of more comprehensive hospital service line relationship



Compensation for Management Services

- From hospital's perspective, think of it as department management "outsourcing"
- Billing & collections (revenue cycle)
- Service line staffing
- Programmatic examples:
  - Implement and manage pathways program
  - Implement and manage QOPI program
  - Implement and manage oncology medical home

Billing & Collections (Revenue Cycle)

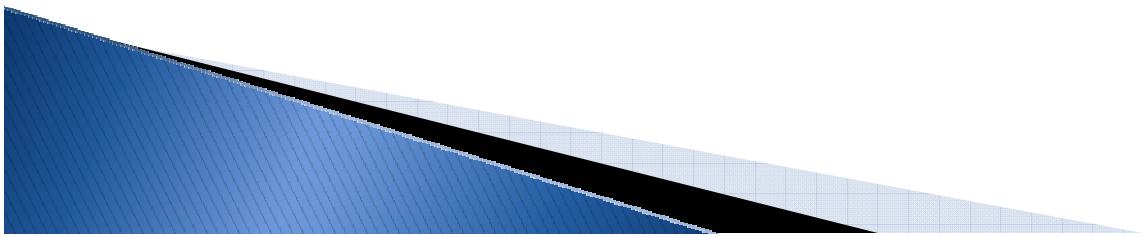
- Practice assumes responsibility for oncology-specific revenue cycle: pre-authorization, charge capture, coding, claims submission, tracking, denials management, rebilling, posting
- Compensation: ranges from 4% to 6% net revenues (collections)*
- Difficult to implement: choice of billing system, interface/integration with hospital enterprise-wide systems; reconcile with hospital admissions and finance functions; risk of compromised and unworkable hybrid systems.

*this example not to be construed as an opinion of appraised value

Service Line Staffing

- Practice provides personnel to staff service line functions - clinical and/or business functions ("employee leasing");
- Can't "double dip" for billing & collections staff
- Need clear lines of reporting. Hospital v. practice personnel policies. Hospital v. practice benefit package
- Compensation: payroll cost plus 5% to 10%*

*this example not to be construed as an opinion of appraised value



Implement and Manage Clinical Pathways Program

- Practice “disease committees” refine guidelines (NCCN) or purchase turnkey pathways program (D3, P4) for service line-wide application
- Chemo regimen pathways or expanded scope (include radiation for example)
- Process for routinely updating pathways and “enforcing” compliance
- A powerful tool for enabling an enhanced service line medical director role;
- Compensation: range of $40 K annual depending on number of disease committee functions*

*this example not to be construed as an opinion of appraised value

Implement and Manage QOPI Program

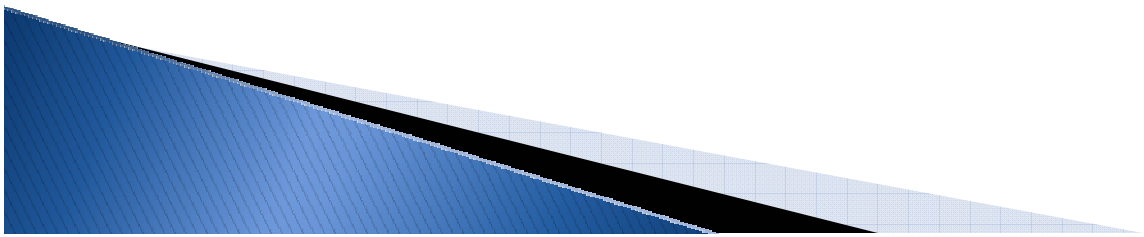
- Practice implements and manages Quality Oncology Practice Initiative (QOPI) program service line-wide;
- QOPI is an ASCO program with 89 measures oncology-specific measures – a “plug in” for hospital service line
- Compensation: range of $100 K annual*

*this example not to be construed as an opinion of appraised value

Implement and Manage Oncology Medical Home

- Oncology medical home (OMH) is a developing model
- OMH designed to aggressively manage symptoms with resulting reduction in ER, hospitalization and drug costs
- Health plans actively experimenting with OMH payment methodologies with enhanced payment to participating providers, for example, increase E&M by10% to 20% or medical shared savings over control group*
- A new construct for oncologist-hospital alignment in era of ACOs?

*this example not to be construed as an opinion of appraised value



Related Article

In your Summit thumb drive:

Oncologist-Hospital Alignment Models Built to Compensate Oncologists Fairly. Barkley and Guidi. *Journal Oncology Practice* (JOP). Vol. 7, Issue 4. July 2011 pg 263-266.

Valuation Issues

- **Jen Johnson, CFA, Partner**
  - Professional Service Agreements Division
  - Previously with KPMG's litigation department
  - Former Finance professor from the University of North Texas
  - Published and presented multiple times related to physician compensation and fair market value
    - Healthcare Financial Management
    - Compliance Today
    - American Health Lawyers Weekly
    - American Bar Association
  - Presentation Overview
    - Understanding FMV
    - Quality Incentives

Valuation Overview

- Agreement structures becoming more multi-faceted
- Agreement Terms must be understood and are often unclear at valuation stage, define:
  - What services will be provided
  - How parties will be compensated
  - Who is at risk
  - Valuation should match the agreement
- No published standards for physician compensation valuations
  - Appraisal firm should understand
    - Healthcare regulations
    - Valuation principles
  - Regulatory Guidance
    - Fair Market Value
    - Data considerations
  - Business valuation standards - a good place to start

Fair Market Value Guidelines

Based on the anti kickback statute, and other healthcare regulations and guidelines, any transaction between hospitals and physicians must be at Fair Market Value.

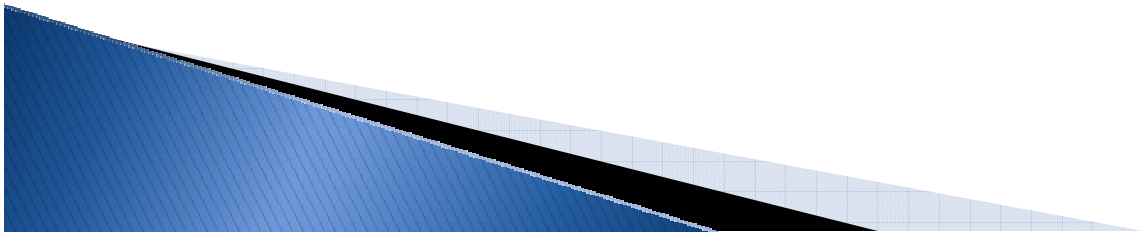
- IRS definition - “the amount at which property would change hands between a willing seller and a willing buyer when the former is not under any compulsion to buy and the latter is not under any compulsion to sell and when both have reasonable knowledge of the relevant facts.”
- Provides a conclusion which should not reflect consideration for value or volume of referrals.
- Rely upon generally accepted valuation theory – consider multiple valuation methodologies and approaches: cost, market and income approach

Data Considerations and Challenges

- Multiple, objective surveys
  - Previous Stark guidance, MGMA alone could be scrutinized
- Data should not reflect referral relationships
  - Medical Director data
  - On-Call data
  - Administrative services
  - Competing Hospitals – Extra Caution
- Clinical compensation determination
  - Historical Compensation drawbacks
  - Income Approach challenges and relevance
  - Cost-Market Approach – benchmark productivity
  - $/WRVU Data likely overstated due to:
    - Numerator – total compensation may include administrative services
    - Denominator – low producers
    - Example

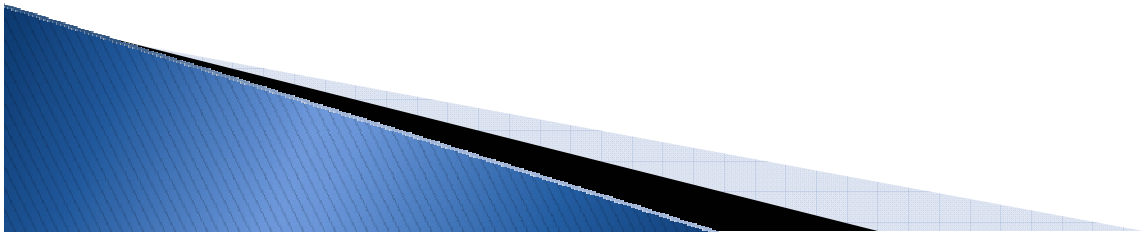
Common Misuse of Survey Data $/WRVU

- Radiation Oncology Example – 90th $/WRVU
  - MGMA 90th Reported Compensation= $781,953
  - MGMA 90th Reported $/WRVU = $107.53
  - MGMA 90th Reported WRVUs = 13.391
  - Calculated Compensation = $1,439,934 (84% above 90th)
  - Hematology/Oncology Same Example
  - Calculated Compensation = $1,107,303 (42% above 90th)
    - When implementing, understand base compensation (if applicable) and threshold that must be met before $/WRVU is paid
    - Always plug in your proposed compensation to expected production to calculate expected compensation…logical sanity check



Valuation Lessons – Tuomey Case
Start with Logic

- Do not pay fulltime benefits/malpractice premiums for part-time services.
- Physicians paid above the 75th percentile of market data should demonstrate productivity consistent with this productivity.
- Understand arrangements where the provider is not making money.
- Compensation for administrative duties should be based on significant duties.
- Methodology of valuation is as important as total compensation.
- Creative arrangements need to be carefully constructed, the government suggests getting an OIG Opinion.
- No opinion shopping, carefully choose your valuation firm.



Valuation Take-Aways

- Understand agreement Terms
  - What are the services?
  - Who is at risk?
  - Who is billing and collecting?
- Consider all facts and circumstances
  - Survey data
  - Credentials
  - Productivity
  - Payor mix, expense profile
- Use multiple valuation methodologies
- Commercially Reasonable
    - Facility needs – overlap of services
    - Operational assessment
    - Understand total hours

Evolution of Hospital Quality Incentive Arrangements

- Hospitals critical success factors – shifting towards quality of clinical performance
- In late 2003, CMS and Premier Inc. launched the Hospital Quality Incentive Demonstration (HQID) for over 250 hospitals
  - Offering financial incentives to improve the quality of health care
  - Includes financial incentives for the top 20 percent of hospitals.
  - Top 10 percent of hospitals receive an incentive payment of 2 percent of reimbursement
- Congress authorized the development and implementation of a value-based purchasing (VBP) program to replace the RHQDAPU program which reports quality (the precursor).
  - Performance (Incentives) would be based on either improving historical performance or attaining superior outcomes compared with national benchmarks.
  - The VBP program is currently being tested
  - Proposed ACOs include similar guidelines
- Numerous third party payors provide P4P payments to hospitals and physicians

Results of Quality Incentive Arrangements

- Hospital Quality Incentive Demonstration (HQID),
  - Raised overall quality by an average of 17 percent over its first four years with total payments in excess of $36.6 million.
  - Majority of hospitals improved their quality of care across the board with respect to reliable use of scientifically based practices
- In 2008, the Robert Wood Johnson Foundation and California HealthCare Foundation reported results of a national program that tested the use of financial incentives to improve the quality of health care.
  - Tested seven projects across the nation that adjusted compensation based on performance scores – hospitals and physicians.
  - Among the notable findings from the program were that:
    - Financial incentives motivate change
    - Alignment with physicians is a critical activity for quality outcomes
    - Public reporting is a strong catalyst for providers to improve care
- Less favorable findings and why

Quality Incentives – Regulatory Guidance

OIG & CMS guidelines provide a solid foundation regarding structuring quality care arrangements:

- Quality measures should be clearly and separately identified.
- Quality measures should utilize an objective methodology verifiable by credible medical evidence.
- Quality measures should be reasonably related to the hospital's practice and consider patient population.
- Do not consider the value or volume of referrals. Consider an incentive program offered to all applicable providers.
- Incentive payments should consider the hospital's historical baseline data and target levels developed by national benchmarks.
- Thresholds should exist where no payment will accrue and should be updated annually based on new baseline data.
- Hospitals should monitor the incentive program to protect against the increase in patient fees and the reduction in patient care.
- Incentive payments should be set at FMV.

Co-Management Arrangement - Structure

- Structure and terms of the arrangement should be clearly defined before valuing compensation.
- Common compensation structures for co-management agreements:
  - Fixed Fee
    - Time dedicated to meetings designed to improve the overall quality of care for a specific service line.
    - FMV based on cost to engage a physician to provide similar services.
      - Clinical and administrative survey data
      - Hourly rate
    - May include
      - Call coverage
      - Medical directorships
      - Non-physician services: billing, administration
  - Variable Fee (also seen in employment agreements)
    - Quality targets are outlined and incentive payments are provided for those responsible for implementing best practices to achieve the predefined targets.
      - Must understand historical, superior quality and improvement
      - Carefully calculate incentive compensation pool – Tiered structure
  - A note about IRS Revenue Procedure 97-13

Quality Metrics in Oncology - Challenges

- Common co-management service lines: orthopedic surgery, cardiology, ASC ->HOPD
  - Patient satisfaction
  - Infection Rates
  - Readmission
  - Mortality
  - *Many P4P observed metrics are not relevant for oncology…
- Predicting what will be incentivized and identifying support for quality payments in oncology
  - Look to current PQRI measures
  - Track what credible oncology organizations are measuring
  - Identify metrics third party payors are relying upon in oncology
  - CMS metrics

Quality Metrics in Oncology – Starting Points

P4P programs start with reporting - 2011 Physician Quality Reporting System (Physician Quality Reporting)

Each measuring the percentage of patients:

- **Oncology: Medical and Radiation – Pain Intensity Quantified**
- **Oncology: Medical and Radiation – Plan of Care for Pain**
- **Oncology: Radiation Dose Limits to Normal Tissues**
- **Oncology: Cancer Stage Documented**

*More detailed descriptions can be found on CMS web site

Quality Metrics in Oncology

PQRI - Measure/Developer Organizations

- ASTRO - American Society for Therapeutic Radiology and Oncology
- American Medical Association-sponsored Physician Consortium on Performance Improvement
- National Comprehensive Cancer Network

ASCO – American Society of Clinical Oncology

- QOPI - The Quality Oncology Practice Initiative
- Fall 2011 measures total 89
- Types of measures
  - Documentation
  - Counseling completed
  - Recommendations and timing for treatments
- Domains
  - Core
  - Symptom/Toxicity management
  - Care at end of life
  - Disease Specific: Breast, Colon/Rectal, Non-Hodgkin's Lymphoma, Lung,

Compensation Models to Align Hospital & Oncologist Interests

Thank You for Participating with Us

Audience Questions & Answers

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