Anatomy of a Cancer Center Transaction

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This is the first of a two-part article comparing two models for structuring a community-based cancer center on a collaborative basis between oncologists and a hospital. This article is adapted from a session entitled "Anatomy of a Cancer Center Transaction" presented at the 2009 Cancer Center Business Summit.[1] That session involved a mock negotiation between community oncologists and a community hospital that was based on the fact pattern described here. In this issue, an on-campus private practice model is examined. In the second installment, which will appear in the next issue of *Journal of Oncology Practice*, an alternative hospital-licensed service model and associated oncology service line comanagement agreement will be discussed.

Background

Today's health care economic environment is adversely affecting all cancer care providers and has been particularly challenging for community oncology. Governmental and private payers are targeting margins earned by oncologists on chemotherapy-related drugs, imaging, and radiation therapy procedures. Questions are also being raised about potential overutilization of oncology services, particularly in relation to the cost-benefit ratio of expensive later-stage cancer treatments.

As a result of these economic factors, community oncologists today find themselves caught in a financial squeeze. Payment rates for oncology services are not keeping pace with rising operating costs or with the cost of new medical devices, new pharmaceuticals, and new information technologies (ITs). Government and payer expectations of documented quality of care are also adding to the cost burden.

At the same time, to rein in health care costs—which are rising at an unsustainable rate—governmental and private payers are beginning to experiment with payment methodologies that are not based on the traditional fee-for-service payments that raise costs by rewarding the provision of ever more services. Instead, payers are starting to set their sights on shared savings, bundled payment, case rates, and global payment arrangements. Anticipation of this change in payment methodologies is accelerating the most pronounced trend in the hospital sector: direct employment of physicians, including oncologists. Hospitals are employing physicians to position themselves to benefit from these new payment arrangements. Some community-based oncologists are ready to become employees of hospitals. They are ready to throw in the towel and accept hospital employment in response to eroding financial conditions for community oncology. Others, though, are more interested in exploring affiliation or collaboration options that hold the promise of preserving a continuing robust role for independent private practice groups.

The bottom line is that the traditional form of community-based oncology practice is being challenged to face new economic realities and reassess its position in the larger evolving scheme of cancer care delivery. Will bigger be better? Will diversification be better? Will affiliation with other oncologists, specialists, or primary care physicians be better? Will collaboration with a hospital, practice management company, insurance company, or vendor be better? One way or another, we believe that a key to survival as a private group practice will be the ability to adapt to changed circumstances.

The following case study shows how two oncology groups assess together their strategic options and begin the change process. We present two models for structuring a community-based cancer center through collaborative arrangements between oncologists and a hospital. Both models have the potential to position all parties for future success while preserving at least a modicum of independent private practice for the community oncologists.

Case Study Setting

The setting is a people-friendly, middle America, two-hospital town (population 200,000). It is in a state with no Certificate of Need legislation, and this permits hospital employment of physicians. The payer mix for oncology services in the town is approximately 60% Medicare, 30% commercial insurance, and 10% Medicaid and uninsured.

The principal stakeholders in our mock negotiation are a five-physician medical oncology group, Medical Oncology Associates (MOA); a three-physician radiation oncology group, Radiation Oncology Associates (ROA); and a 350-bed community hospital, Highland Hospital. There is another competing private medical oncology group in town with three medical oncologists who are being courted for employment by the competing hospital in town, St Josephine's. St Josephine's already employs two radiation oncologists, who are the only direct competitors of ROA.

Both hospitals are interested in developing a new comprehensive cancer center. St Josephine's is only willing to work with physicians on an employment basis. Highland Hospital, on the other hand, has approached both MOA and ROA, offering to explore potential collaborative private practice/hospital arrangements (often referred to as relationship or affiliation models) for its new cancer center.

MOA Meets With ROA

Before deciding whether to discuss a potential collaboration with Highland Hospital, the practice leaders of MOA and ROA

meet to consider first, whether to try to combine forces or go it alone; second, whether there are other strategic partners with whom the oncologists should consider affiliating; and third, whether Highland Hospital is the best strategic partner for the two oncology groups.

One basic theme that emerges from the physician-to-physician dialogue is that in both the local and general markets, there is strength in numbers. The groups decide they may be better off taking a "united we stand" posture, whether this means first consolidating the two groups or jointly negotiating a three-party collaboration with Highland Hospital. The MOA and ROA practice leaders identify the following potential benefits of the two groups coming together for these purposes:

- Potential market growth opportunity
- ROA relies on MOA referrals and does not want MOA to align with employed ROs at St Josephine's
- Enhanced bargaining power in negotiations with Highland Hospital
- Service diversification
- Integrated multidisciplinary patient experience
- Quality and efficiency improvements from coordinated care
- Better positioning in the event of reimbursement erosion or trend toward bundled payments
- Share ancillary service revenues
- Access to expanded range of more profitable clinical trials

Although there are advantages that may flow from merging their practices, the physicians acknowledge there are significant obstacles to a successful merger that need to be realistically assessed and overcome. Those obstacles include:

- Agreeing on shared governance
- Agreeing on shared economics
- Change of brand identity
- Impact on referral sources (eg, loss of referrals to ROA by the competing MO group at St Josephine's)
- Different practice cultures
- Different IT platforms and recent IT investments
- Different billing arrangements and reimbursement rates
- Different practice debt profiles
- Different physician compensation and benefit structures
- Different practice buy-sell arrangements
- Different relative valuation of practices

In the end, the physicians conclude that it may be worthwhile to consolidate practices, but it would not be easy and would take considerable time and resources to accomplish. For the time being, they decide to defer additional consideration of a practice merger until after they determine whether they can collaborate with Highland Hospital on a three-party basis. If they can do a three-party deal, this may obviate the need to go through the exercise of trying to merge their practices. They decide to set up an appointment to meet jointly with the hospital.

Physicians Meet With Hospital

The MOA and ROA practice leaders meet with the chief executive officer of Highland Hospital to explore the potential for a three-way collaboration. Experienced health care transactional counsel is asked to join the meeting. The lawyer has been engaged as project counsel rather than as counsel to any particular party. The project counsel role is to provide an objective broker in helping the parties identify legally compliant options for structuring a collaborative cancer center arrangement that meets their common business goals. Project counsel is tasked with identifying the parties' common interests and facilitating their consideration of potential win-win transaction structures.

Hospital Perspective

The Highland Hospital chief executive officer begins by suggesting a potential set of common goals and objectives. Highland Hospital envisions establishing a new multidisciplinary cancer care center of excellence for the benefit of the community founded on the following guiding principles:

- Win-win-win collaboration to provide a needed health care resource to the community while growing market share for all and maintaining/enhancing hospital margins
- Position all for future changes in payment methodologies (bundled pricing, epodes of care, case rates, and so on)
- Align hospital and physician interests around quality and efficiency
- Share responsibilities, risks, and rewards of cancer center operations
- Protect against destructive competition among the parties
- Maintain consistency with the tax-exempt mission of the hospital, including serving all patients regardless of ability to pay
- Comply with regulatory requirements (eg, Stark law, anti-kickback statute, and so on)
- Demonstrate operational and financial feasibility
- Maintain durability/sustainability and be a proud legacy for all involved
- Build on a foundation of mutual respect and trust

Physician Perspective

MOA and ROA physician leaders generally subscribe to the guiding principles of Highland Hospital. However, they are skeptical about the ability of the hospital to be a good business partner and need convincing that foreseeable problems can and will be addressed and resolved on a mutually agreeable basis. They raise questions about the following:

- Historical inequality of resources and limited access to business information that have caused suspicion and mistrust of hospitals among physicians
- Hospital with multiple priorities, not principally oncology focused, which could affect future resource allocation
- Potential clash between the physician cultural desire for practice autonomy and the hospital institutional culture of bureaucracy and control
- Relatively slower pace of decision making by hospitals versus quicker decision making ability of a medical practice
- Hospital information systems and operating procedures being generally more cumbersome and expensive compared with private practice systems
- More expensive cost/overhead structure of hospitals as opposed to the lower wage/benefit scales and overhead cost structures of private physician practices

- Loss of referrals from primary care physicians and others employed by St Josephine's
- Possibility of MOA/ROA going it alone without any hospital partner and associated financial and competitive risks

On the other hand, the physicians recognize that a relationship with the hospital may help to stabilize the economics of their private practices in the face of declining reimbursement in general and potential sweeping changes in payment methodologies under health reform. MOA emphasizes that as a private practice, it simply can no longer afford to subsidize the cost of chemotherapy drugs for indigent and underinsured patients.

The parties decide to proceed with exploring a potential three-party collaboration. The overriding consideration for all is their common desire to meet the competitive threat of St Josephine's and its employment model in the local marketplace. All parties believe that they would be better off collaborating to capture and grow oncology market share for their mutual benefit. They view this as preferable to each going its own way and potentially ending up with three competing cancer programs in this modest-sized regional market. Accordingly, the parties agree that collaboration may be their best strategic option. They decide to proceed in this direction if there is a legally compliant way to do so that is consistent with their common vision and respective goals.

Project counsel is tasked with developing and presenting collaborative arrangements that may meet those goals. After meeting separately with each of the parties to better understand their differing perspectives and interests, he offers two general business models for initial exploration and indicates that there are a number of variables in each model that can be changed to suit the parties. The first is the on-campus private practice model, and the second is the hospital-licensed service model, which involves a modified under arrangement joint venture and service line comanagement agreement. The first model (along with some of its variants) is discussed in this issue. The second model will be examined in the next issue of *JOP*.

Model 1: On-Campus Private Practice

In model 1, Highland Hospital incurs the cost of developing a new, fully furnished and equipped, on-campus cancer center. The medical oncologists would lease space in the new cancer center and relocate their private practice. The medical oncologists would provide infusion and medical oncology services in their office space in the cancer center and bill for those services under the provider numbers of MOA. MOA would therefore be paid at physician-level reimbursement rates. The space would be somewhat more expensive on a per-square-foot basis than the current MOA space, because it would be new construction, and the hospital requires all on-campus space to be built to hospital outpatient physical space specifications. The hospital also has a restriction in its leases with all on-campus medical groups that prohibits them from providing laboratory, imaging, or other ancillary services in their offices. To accommodate this restriction, it is proposed that the medical oncologists sell their laboratory equipment to the hospital for fair market value and transfer their laboratory personnel to the hospital and that the hospital thereafter run a satellite laboratory immediately adjacent to the private practice space of MOA. The hospital laboratory would be integrated with the MOA patient workflow.

An MOA physician would become the MO medical director of the cancer center, and an ROA physician would become the RO medical director of the cancer center. Both groups would be paid $75,000 per year for these medical director services, which represents a fair market rate for the projected number of hours of work involved. In addition, MOA would have the option of leasing ROA physicians from ROA on a leased employee basis. This would let MOA realize any upside growth in the professional component of RO services at the cancer center while guaranteeing ROA compensation under the employee lease for its physicians at their current compensation rates (inflation adjusted). This would shelter ROA from any reduction in reimbursement for the professional component of RO services. MOA would need to absorb that downside risk to get the upside potential from any growth in RO professional services.

Highland Hospital currently owns the linear accelerators that ROA uses, and the hospital currently provides the technical component of RO services. It would continue to do so at the new cancer center. Alternatively, the hospital could create a joint venture with ROA regarding the radiation technology (RT) equipment, and the joint venture would lease the RT equipment either to ROA, which would bill for the technical component services as physician services, or to the hospital, which would continue to bill for the technical component services as hospital services. Through this means, ROA could, for the first time, obtain an interest in the technical component of RT services, at the expense of some reduction in the margin on hospital RT services.

Highland Hospital would also provide laboratory, imaging, and other ancillary services at the cancer center as hospital-licensed services. Although there would be no obligation for MOA or ROA to refer patients to Highland Hospital, the hospital anticipates that this collaborative arrangement would grow both its outpatient and inpatient oncology volume as well as its volume of ancillary services. Figure 1 illustrates the relation-

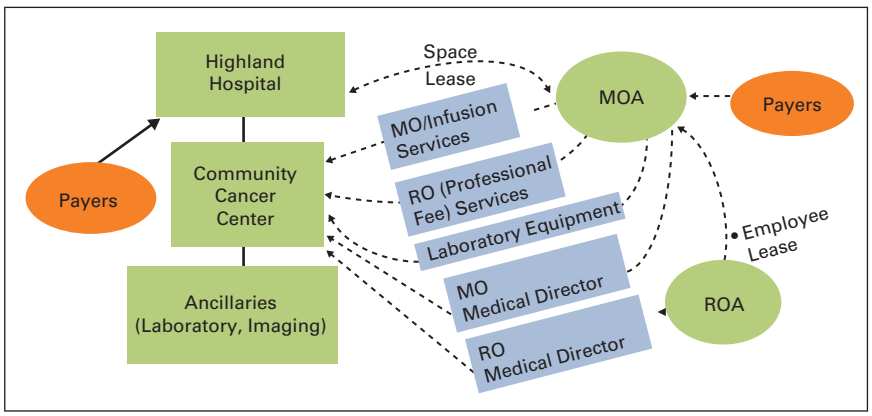

Figure 1. On-campus private practice model. MO, medical oncology; MOA, Medical Oncology Associates; RO, radiation oncology; ROA, Radiation Oncology Associates.

Table 1. Model 1 Scorecard

Financial Change	MOA	ROA	Highland Hospital
Old revenue	—Keeps infusion revenue	—Gets guarantee of existing professional fees?	
New revenue	—FMV of laboratory equipment	—RO medical director fee	—Ancillaries: laboratory, imaging
	—MO medical director fee	—Shared RT technical component?	—New admissions
	—Growth in RO professional services?		
New costs	—Higher space lease cost?	None	—Finance development of cancer center (space, equipment)
	—Parking for employees?		—Pay for laboratory equipment; incur laboratory personnel costs
	—Loss of laboratory margin (if any) *v* reduced laboratory staff costs		—Incur medical director fees
	—RO staff lease cost (including ramp-up)		—RT joint venture costs; reduction in RO technical component margin?

Abbreviations: MOA, Medical Oncology Associates; ROA, Radiation Oncology Associates; FMV, fair market value; RO, radiation oncology; MO, medical oncology; RT, radiation technology.

ships in the on-campus private practice model. This model allows some opportunity for clinical and economic integration while meeting the physicians' objective of maintaining practice autonomy and independence.

From a federal health regulatory perspective, all of the model 1 transactions would need to be arms-length fixed-fee, fair market value transactions that are set in advance and do not vary with the volume or value of referrals or business generated between the parties. An independent appraisal of the fair market value of the various transactions is strongly advised to help assure regulatory compliance. Table 1 lists new revenue opportunities and identifies potential new costs for each of the three parties in model 1.

In addition, as of October 1, 2009, the Stark law rules changed to prohibit percentage-based or per-unit-of-service payment arrangements under space and equipment leases. Accordingly, the private practice space in the cancer center rented by MOA, and any RT or other equipment leased (directly or indirectly) by ROA, should not be leased on a percentage of charges, collections, or profits basis or on a per-click basis. (If ROA were to perform only consultative services on order of other physicians and did not itself refer any patients to the hospital, then any lease arrangement between ROA and the hospital would fall outside the scope of the Stark law and could potentially be structured on a percentage or per-click basis.) The fraud and abuse laws would also discourage valuing the MOA laboratory business on an income basis (ie, on a discounted free cash flow basis as a going concern) for purposes of selling it to the hospital, because valuation on this basis would, by definition, take into account anticipated referrals to the laboratory by MOA. Rather, the laboratory equipment would need to be valued on a cost or market basis (ie, at most at the fair market value of the equipment, without any value attributed to goodwill). Furthermore, if the cancer center space or equipment is financed with tax exempt bonds, then IRS Rev. Proc. 97-13 may limit the duration of the lease of any such space or equipment by Highland Hospital to MOA or ROA to between 2 and 15 years depending on the specific financial terms of the lease.

In the next issue of *JOP*, we will describe model 2, present an economic comparison of the two models, and reveal which model was chosen by the parties in this case study scenario.

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Reference

1. Anatomy of a Cancer Center Transaction. Presented at the 2009 Cancer Center Business Summit, Dallas, TX, October 8-9, 2009