

# Oncologist-Hospital Alignment Models Built to Compensate Oncologists Fairly

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## Abstract

Reimbursement for services is down; practice overhead is up; community oncologist take-home income continues to erode—that is a common scenario today. No wonder community oncologists are interested in exploring alignment relationships with hospitals and academic medical centers. It can actually work too: fragmented services can

be consolidated; oncologist incomes can be stabilized; communities can be better served. But what can oncologists entering into these relationships expect to be paid for their professional contribution? This article describes approaches to structuring an oncologist-hospital alignment relationship and compensation methodologies applicable to each.

## Today's Common Scenario

We have heard rumblings that the traditional small private practice model may be a dinosaur in the brave new world of accountable care as community oncologist interest in exploring alignment relationships with community hospitals and academic medical centers increases. With the unknowns of health care reform, a safe and secure alignment that integrates the oncologist with a hospital can be seductive—fragmented services can be consolidated and redundancies eliminated; oncologist incomes can be stabilized; truly comprehensive cancer care service lines can be organized; and communities can be better served. But how can the relationship be structured to fairly compensate oncologists for their professional contribution? There are several basic approaches to structuring such alignments and this article will describe the approaches and provide examples of oncologist compensation methodologies applicable to each.

## Four Basic Approaches

The basic structuring approaches include (1) direct employment, (2) a professional service agreement (PSA), (3) a management service agreement (MSA), and (4) a comanagement agreement (CMA). A working assumption for these approaches is that the hospital—not the oncologist(s)—is the service provider for either or both of the professional and technical (infusion) components of care. This is referred to as a provider-based service and is typically classified as a hospital outpatient department. If both the technical and the professional services are characterized as being provider-based, then the hospital is reimbursed for both. Alternatively, only the technical (infusion) service may be provider-based whereas the professional services remain office-based and are billed accordingly as a physician service.

### Approach One: Direct Employment

Hospital direct employment of a physician is about as straightforward as it gets. The physician provides medical services to hospital patients, and in return, the physician gets a paycheck. The rate of pay is negotiable, depending on local market cir-

cumstances and subject to the limitations of a fair market value (FMV) rate.

A variation on direct employment by the hospital itself is to have the oncologist(s) employed by a hospital-affiliated captive medical group or network. Note that in some states, California for example, it is unlawful for a physician to practice as an employee of a nonphysician such as a hospital (the so-called corporate practice of medicine doctrine). Thus direct physician employment by a hospital may not be possible in some jurisdictions.

The negotiated pay rate could be expected to follow the basic principles of supply and demand. For example, the greater the supply of qualified oncologists lined up at the hospital recruiter's door, the more likely that the competitive pay rate will be relatively lower ("buyer's market"). The inverse could also be expected to hold—that is, if there is only one qualified oncologist available to accept hospital employment and the hospital is seeking to fill four slots, the competitive pay rate would be higher ("seller's market"). The basic compensation methodologies include a fixed salary, productivity-based compensation, and performance-based bonuses. Examples of compensation calculations under these methodologies are provided in the Oncologist Compensation Methodologies section.

If an oncologist is new to practice or is perhaps an experienced oncologist relocating to the area but with no existing practice, then hospital employment can likely proceed without impediment. But what if an oncologist, or more likely an organized medical group practice of oncologists, has an existing, thriving practice? Is the hospital willing to purchase the practice to facilitate the alignment? It is common that a hospital acquires the candidate oncologist(s) practice. Practice purchase prices are generally limited to the applicable FMV price, which in the context of a practice acquisition by a hospital, consists of the practice's hard assets such as furniture, fixtures and equipment, and inventory but without assigning value to the practice's intangible assets, which are referred to as "goodwill" or as "going concern" value. However, there are certain elements of goodwill/going concern that should be considered when arriving at a practice's purchase price, such as the value of the workforce in

place (or the cost to replicate) and intellectual property (eg, the value of proprietary clinical pathways).<sup>1</sup> Our recommendation is that, in arriving at a practice's purchase price, insist on a valuation firm that has experience in the nuances of valuing medical practices.<sup>2</sup>

### Approach Two: PSA

Historically, physicians have shied away from employment by hospitals out of concern for loss of professional autonomy, concern for becoming subjected to hospital bureaucracy, and general trust issues. In response to physician anxieties associated with direct hospital employment, the PSA approach has become a popular alignment vehicle that is one step removed from direct employment and that preserves at least a modicum of private practice.

In a PSA scenario, the hospital contracts with the oncologist, or more typically a group of oncologists, to provide services to hospital patients. The practice stays intact and oncologists can look at the PSA solely as a different method of reimbursement (hospital as single payor rather than multiple health insurance contracts). In some situations, the PSA is not the exclusive source of income for the practice. Instead, a practice may continue to generate revenues as private physician office billings for its patients in some locations while concurrently servicing a hospital PSA in other locations. Consider this to be a hedge-your-bets diversification strategy.

### Approach Three: MSA

Since the mid-1980s, chemotherapy/infusion services have predominantly been provided in the office-based domain. Thus, in most community settings, it is the oncology practice that has the systems and staff to successfully conduct chemotherapy/infusion operations. Given this dynamic, it makes sense in planning an alignment to consider delegating to practice systems and talent the responsibility for operations of some or all of the hospital's oncology service line. Delivering best-of-class staff and systems to the hospital oncology service line can be done through a contractual relationship, generally characterized as an MSA. Under an MSA, a hospital purchases management services from a practice. Those services might include oncology billing services, nonphysician staffing, service line development, and oncologist supervision/oversight of chemotherapy services.

Management services can be provided independent of a PSA relationship and documented in a separate MSA agreement or often times combined with a PSA. We like to think of this as a PSA on steroids or a PSMA, in which the *M* stands for management services contained within a PSA. These acronyms are often used interchangeably, so don't be confused by the label. Look to the rights and obligations in the agreement itself to understand the scope of the alignment relationship.

*Billing services.* A practice might provide oncology-specific coding, data entry, billing services using the practice's billing staff who already have a command of the complexity of billing for infusion services and drugs. Although the nuances of billing for hospital-based infusion services differ somewhat from those of

office-based billing, a skilled biller can readily adapt to the differences and quickly master billing on a UB04 (the hospital's claim form). Often the greatest challenge stems from the data systems that feed the claims production software, particularly because there are numerous fields on the UB04 that are populated with information that does not reside in the practice's systems (eg, revenue codes). The going rate for oncology billing services ranges from 4% to 6% of collections, according to an independent survey of medical billing companies in 2009.<sup>2a</sup>

*Nonphysician staff leasing.* To access trained staff without recreating the workforce, a hospital can lease nonphysician support staff from the practice. As with billing services, the office-based personnel may be more comfortable and more efficient in this outpatient work environment than current hospital-employed staff, particularly if the hospital has not previously had a robust hospital outpatient infusion center. In addition, with the growing shortage of oncology nurses, this offers the hospital access to trained and experienced staff. A common formula for staff leasing services in an MSA is actual payroll cost plus a percentage for personnel management expressed in the range of 4.5% to 9% of payroll cost, according to an appraiser's analysis of gross margins of the employee leasing industry and factoring in the differences between economies of scale expected of a large industry staffing company compared with a private medical practice.

*Management services.* Operational expertise gained in the office-based environment can bring value to the hospital outpatient setting. Practice expertise transferable to the hospital setting includes supervision/management of chemotherapy services and service line program development and program implementation such as quality programs, multidisciplinary care constructs, cancer survivorship programs, and clinical pathways implementation and compliance—all of which can be important elements of an accountable care initiative.

### Approach Four: CMA

A variation on the PSA/MSA situation is one in which the hospital assumes all of the practice operating infrastructure (staff, facilities, equipment) and redeploys it in the operation of the hospital's oncology service line, but the practice continues to provide and bill for professional medical services (evaluation and management) as an office-based service. In this variation, in which the oncologists are no longer billing for drug and/or drug administration services, a mechanism for replacing the lost drug and administration revenues is indicated. One approach to address this issue is the CMA, under which the practice is paid a fee for providing chemotherapy/infusion medical oversight and related services to the hospital program. Under a CMA, the hospital and the oncologist(s) are jointly responsible for managing a defined set of services and meeting defined performance targets, and they share in the financial results of achieving such performance results. These are often structured with a fixed base compensation to physicians that is supplemented by performance-based compensation for meeting or exceeding established targets. Elements of a CMA can be documented in a

separate agreement or contained within one of the other alignment forms (ie, PSA, MSA, or PSMA).

In some instances, medical oncologists have consolidated with other related oncology specialties (radiation, gynecology, breast surgery, urology) into an integrated specialty group practice that expands the service capabilities and broadens the scope of responsibilities under a CMA construct.

### A Word About FMV

For the purposes of health care regulatory compliance, financial arrangements (including compensation or practice acquisition price) must be set at FMV as determined through independent appraisal. Hospital payments to physicians are governed at federal law by the Stark Law (42 U.S.C. Sec. 1395) and the Anti-Kickback Statutes (42 U.S.C. Sec 1320a-7b[2]). Exceptions to application of these regulations are based, in part, on determination that payments are reasonable and at fair market value rates. It should be anticipated that a third party FMV appraisal of any financial arrangements will be conducted before a hospital will be comfortable moving forward with any alignment. FMV appraisals can be detailed and time-consuming and can vary widely in result. Costs for such FMV appraisal can range from \$10,000 to \$15,000 for a straightforward asset appraisal (value of equipment and furniture, for example) to \$75,000 to \$100,000 for more complex practice appraisals. Our recommendation is to get agreement up front as to who is paying for the cost of any appraisal(s) associated with the contemplated alignment.

### A Word About Hiring an Advisor

Oncologist-hospital alignment is a complex and rapidly evolving subject. Migrating to a hospital alignment relationship necessitates forging a new working relationship between historic mutually dependent adversaries: physicians and hospitals. For these two reasons—transaction and relationship complexities—it is recommended that the physician and hospital stakeholders engage experienced professional help early in the dialogue, preferably at the point when the physician and hospital stakeholders agree to do something together. Call this the letter-of-intent stage. Professional advisors can come in the form of consultant, transaction attorney, or accountant. Invariably, all of these disciplines become involved in the structuring and budgeting of an alignment, but it is wise to start off by engaging an experienced consultant champion to guide and package the alignment on behalf of all stakeholders in a manner that avoids false starts and work redundancies through a process that can take anywhere from 12 to 30 months to conclude.

### Oncologist Compensation Methodologies

The basic compensation methodologies found in oncologist-hospital alignment relationships are (1) a fixed salary, (2) productivity-based compensation, or (3) performance-based bonuses. These methodologies apply to oncologist compensation whether in a direct employment or a PSA situation. A key consideration is that the compensation must be reasonable as measured by independent fair market appraisal. When per-

forming their appraisals, valuation advisers will typically reference, among other sources, the Medical Group Management Association's (MGMA's) Physician Compensation and Production Survey.<sup>3</sup> In the MGMA survey, results are compared annually for single specialty and multispecialty settings by geographic region and by quartile performance.

*Fixed salary.* Determining salary is a matter of negotiating the rate by taking into consideration the experience level of the oncologist(s) and local factors, including manpower supply and demand. The MGMA survey can be instructive in this regard. For example, if the oncologist is coming from a single-specialty hematology/oncology practice in the Midwest and has 10 years of solid experience, an FMV annual salary is somewhere between the MGMA median and the 75th percentile at about \$400,000.

*Productivity-based compensation.* Rather than a fixed salary, the compensation methodology used in many hospital alignments is productivity-based compensation, which means paying a work relative value unit (wRVU) rate for oncologist professional services.<sup>4</sup> A rule of thumb is that a busy full-time hematologist/oncologist will generate in the range of 5,000 to 6,000 wRVUs annually for office-based and hospital inpatient services. The MGMA survey<sup>3</sup> provides guidelines for the dollar amount associated with wRVUs by region. For example, per the MGMA survey, a FMV rate per wRVU for an oncologist located in the Eastern region of the country might be \$88 to \$110 per wRVU. Assume that the per wRVU rate negotiated with the hospital is mid-range at \$100. Then our Eastern region–based oncologist who is generating 5,000 wRVUs annual could expect to earn \$500,000 a year under this formula, assuming that the oncologist's wRVU production stays relatively constant.

A cautionary note about RVUs: make sure that all parties clearly understand which RVUs are to be counted in an RVU productivity-based compensation formula, and document it in

**Table 1.** Putting It All Together

Revenue-Expense Category	Private Practice (\$)	Hospital Aligned (\$)
Patient gross revenue	52,185,000	
Discount/allowance	-33,455,000	
Net revenue	18,730,000	
Personnel expense	-2,458,000	
Drug, medical supply expense	-12,214,000	
Facilities, G&A expense	-1,605,000	
Total practice overhead expense	-16,277,000	
Productivity compensation (wRVU)		3,150,000
Personnel		75,000
Programs (QOPI, pathways, etc)		125,000
Performance (drug cost reductions)		50,000
Practice liability insurance, accounting, etc		-400,000
Net income pool to pay 6 physicians	2,453,000	3,000,000

Abbreviations: G&A, general and administrative; QOPI, Quality Oncology Practice Initiative; wRVU, work relative value unit.

the respective agreement. For example, it is not uncommon that 20% or more of the wRVUs in the private practice setting may be generated by midlevel providers (nurse practitioner, physician assistant). Are midlevel wRVUs to be counted in the oncologist compensation formula? If not, how will per wRVU rates be adjusted to accommodate the reduction in physician wRVU productivity when moving from office-based to the hospital's provider-based setting? Likewise, chemotherapy administration wRVUs in the office-based setting can account for 10% to 15% of physician wRVUs. Are the oncologists going to be credited for chemotherapy administration wRVUs when they transfer to the provider-based setting? If not, how will the wRVU rate be adjusted to accommodate the loss of historic wRVU production associated with chemotherapy administration? Perhaps under a CMA arrangement?

*Performance-based bonuses.* A performance bonus feature may be added to any compensation arrangement, typically for achieving predetermined targets or measures of performance of success—for example, achieving a targeted patient satisfaction rating, a targeted time from referral to first appointment, a targeted drug cost to charge ratios or compliance with clinical pathways. Performance-based bonuses are often the basis for structuring CMAs.

### Putting It All Together: An Example

Assume that a six-physician medical oncologist practice and a community hospital have agreed to explore an alignment relationship. The hospital agrees to consider acquiring the physician practice assets and subsequently deploy them in the operations of a provider-based oncology service line housed in a hospital-owned on-campus cancer center. Both the technical and the professional components will be billed as provider-based services. The hospital agrees that, in addition to providing oncology professional services, the practice will provide staffing and management of the hospital's medical oncology service line.

One possible alignment solution to the above scenario would be for the hospital to purchase the practice's furniture, fixtures and equipment, and drug and medical supply inventory at an FMV price of \$550,000 and assumes outstanding lease obligations of the practice. The practice enters into a PSMA with the hospital (Table 1).

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Under the terms of the PSMA, the practice is paid \$105 per wRVU generated (including wRVUs generated by a nurse practitioner). The practice has historically generated approximately 30,000 wRVUs annually, which amounts to \$3.15 million per year in professional services compensation. Practice personnel are provided at payroll cost plus a personnel administration fee, which generates an additional \$75,000 annually.

In addition, the practice is paid \$125,000 annually for the implementation and management of a quality program (which the parties agree will be the American Society of Clinical Oncology's Quality Oncology Practice Initiative) and for implementation of and compliance with a clinical pathways program that the hospital has purchased on a subscriber fee basis from a well-known academic medical center. Finally, the practice is paid 50% of drug cost savings achieved through reductions to the oncology-related drug cost to charge ratio below the current level, which is projected to result in bonus of \$50,000. This example and associated financial comparison we describe is derived from field experiences of Cancer Center Business Development Group (Bedford, NH) and Oncology Management Consulting Group (Pipersville, PA).

Putting it all together, the combined compensation features of this oncologist-hospital alignment is expected to generate an annualized compensation improvement of \$547,000 (22%) above that currently experienced by the physicians in the office-based setting and achieve a more integrated and sustainable construct for cancer care delivery in the community.

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