

What You Need to Know *Before* Acquiring an Oncology Practice



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Over the last several years, a remarkable number of private medical oncology groups have shifted to hospital and/or health system employment. As reported in the Medical Group Management Association (MGMA) *Physician Compensation and Production Surveys*, between 2006 and 2011, the percentage of medical oncology physicians employed by hospitals and/or health systems increased from 22 percent to nearly 50 percent (see Figure 1, right). Similarly, a report published by the Community Oncology Alliance indicated that over a three-and-a-half year period, more than 40 percent of the surveyed medical oncology clinics (426 out of 1,042) were acquired by a hospital or other entity.¹

Given the critical importance of the oncology service line, many hospitals and health systems have either acquired a group of medical oncologists or are likely to do so in the near future. While the acquisition of a medical oncology practice offers a variety of benefits to a hospital and/or health system, the expected financial results are frequently not attained. To ensure strong financial performance of the acquired practice, hospitals and health systems must take into consideration a number of issues as discussed below.

Understand the Business Model

Generally, three major components make up a medical oncology practice's business model: a clinical practice, infusion therapy services, and ancillary testing.

Clinical practice. Like other medical specialties, medical oncology physicians provide significant consultative and follow-up patient care in the office and inpatient settings throughout the course of a cancer patient's treatment and survivorship.

Infusion therapy. Oncology treatment requires the administration of therapeutic, chemotherapy, and/or biological agents to patients. The margin on these agents has generally been favorable and contributed substantially to oncologists' incomes.

Ancillary testing. Oncology practices have varying ancillary service capabilities, ranging from laboratory testing to advanced imaging services, such as PET/CT. Not only do these modalities enable physicians to provide more comprehensive and convenient care to patients, but also they economically benefit the practice.

As shown in Figures 2 and 3, page 34, median work relative value unit (WRVU) production levels per physician FTE are similar between internal medicine and hematology/oncology. However, median incomes per physician FTE for hematology/oncology are nearly double those of internal medicine. The difference in income versus WRVU production is due largely to the infusion practice, which generates nominal WRVUs

for the administration of therapeutic agents but substantial income due to the margins on chemotherapy drugs.

As reported in various sources, median drug acquisition costs for medical oncology range from \$2.0 million to \$2.5 million annually per physician FTE.² However, hospitals and health systems need to understand that the attendant operating margins of approximately 8 to 12 percent increase the susceptibility of the financial performance of the medical oncology practice to relatively minor changes in drug costs and/or reimbursement.²

Three key areas typically drive the financial performance of all medical oncology practices (whether employed or independent): drug acquisition costs, reimbursement rates, and patient education and assistance.

To truly understand the financial implications of acquiring a practice and limit the associated business risk, hospitals and health systems should devote considerable time and resources to analyzing these three components. Likewise, hospital and health system leadership must ensure that management implements strong operating practices to support these areas post-transaction.

Drug Acquisition Costs

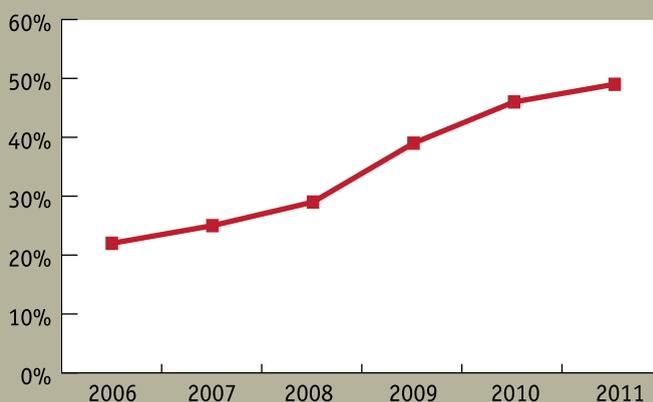
Acquisition costs are derived both from the type and price of purchased products. The factors impacting drug acquisition costs are summarized below.

GPO pricing. Begin by examining negotiated prices for drugs and determining how the group's pricing compares to that of the hospital and/or health system. A medical oncology group may have better pricing on at least some of the most commonly-used drugs. Performing a detailed side-by-side analysis is a good way to identify opportunities to renegotiate GPO contracts. This analysis should also incorporate historical volumes, as drugs with minor cost differences can have a dramatic impact if the volumes are high enough. Depending on the confidentiality terms in the GPO contracts, you may need to enlist the support of a third party to perform this assessment to avoid violating the contract.

Formularies. Today, many hospitals and health systems have established formularies. When undertaking an examination of drug acquisition costs, the P&T committee must have access to the necessary data to make informed choices, particularly with respect to evidence-based medicine and pharmaco-economic decisions. It is also important to ensure that physicians from the medical oncology practice have an opportunity to either present their perspectives to the P&T committee or participate on the P&T committee. (In many cases, a cancer chemotherapy committee, comprised of the oncology pharmacist and medical oncologists, is instituted to refine formulary decisions within a center.) Prior to completing the acquisition, compare the group's formulary or utilization patterns to the the hospital or health system's formulary to identify potential variances and to enable a financial analysis of the implications of the new formulary.

340B Drug Pricing Program. This federal program enables qualifying organizations to purchase outpatient drugs at signifi-

Figure 1. Percentage of Hematology/Oncology Physicians Employed by Hospitals and/or Health Systems



SOURCE: MGMA. PHYSICIAN COMPENSATION AND PRODUCTION SURVEYS, 2007 TO 2012.

cantly discounted prices. The typical savings realized on drug acquisition costs through the 340B program is, on average, about \$500,000 per physician FTE (this data is based on average annual drug expenses of \$2 to \$2.5 million per physician FTE and average savings of 20 to 40 percent.) If the affiliating hospital participates in 340B, the business model should be constructed in a fashion that enables the cancer center to use the program to its fullest, ensuring that all eligible patients (including those who are commercially insured) receive drugs purchased through 340B. The savings from the acquisition price is often re-invested into cancer programming in the form of patient navigators, social workers, and other operational improvements. Notably, hospitals that do not qualify for the 340B program may explore partnerships with affiliated hospitals (located within 35 miles) in their health system to access 340B pricing.

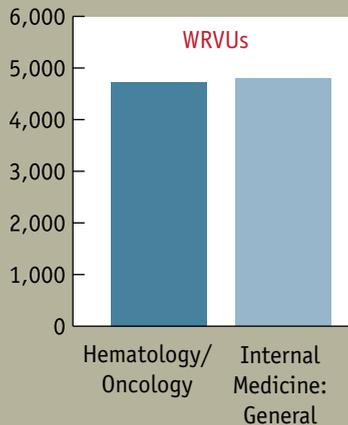
Inventory management. Processes should be in place to monitor compliance with the organization's formulary and use of generic drugs when indicated; formulary compliance not only drives standardization of care, but also enables the organization to leverage the pricing negotiated with the GPO (e.g., lower prices for higher volume drugs). Due to the high cost of pharmaceutical agents, most oncology practices adopt a just-in-time inventory policy, typically receiving drugs less than 24 hours before administering them. If the hospital or health system does not currently have such a model in place, it should work closely with the medical oncology group to develop stringent standards for maintaining low inventories of expensive oncology drugs.

Manufacturer rebates. For years, manufacturers have commonly offered rebates on various brand-name drugs. Hospitals and health systems should work with staff from the medical oncology practice, pharmacy, and finance departments to ensure that the appropriate processes are in place to identify and participate in these programs.

Reimbursement Rates

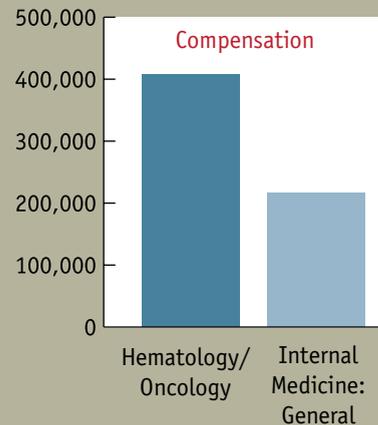
When evaluating reimbursement trends among commercial payers for infusion services, hospitals and health systems

Figure 2. Comparison of Median WRVU Production per FTE



Source: MGMA. *Physician Compensation and Production Survey: 2012 Report Based on 2011 Data.*

Figure 3. Comparison of Median Compensation per FTE



Source: MGMA. *Physician Compensation and Production Survey: 2012 Report Based on 2011 Data.*

should complete two analyses:

- Identify how the oncology service would perform under the hospital or health system's commercial rates
- Identify how commercial rates within the hospital or health system compare if the practice is structured as a hospital outpatient department versus a freestanding practice under the hospital's contracts.

These analyses will point out opportunities to negotiate the most favorable reimbursement rates, as well as determine the impact of remaining a freestanding clinic or designating the infusion clinic as a hospital outpatient department. Due to confidentiality requirements in the associated agreements, you may need to enlist the support of a third party to perform this assessment and report findings and at aggregate level.

Patient Education & Assistance

High-performing medical oncology practices are proactive in their communication with patients, providing an explanation of a patient's third-party payer benefits and the cost of treatment prior to initiating the care regimen. Typical patient education and assistance services include:

- **Pre-authorization.** A financial specialist or staff member evaluates the patient's benefits and determines what the insurance company will pay, as well as the responsibility of the patient.
- **Patient education.** The financial specialist meets with the patient to review the projected cost of care and the patient's responsibility. At this point, staff may discuss payment plan options or explore other alternatives, such as enrollment in financial assistance programs.
- **Provider communication.** Staff will research any disallowances (non-covered services or drugs) by a health plan, so that the decision may be appealed or the course of treatment altered before it commences.
- **Replacement drugs.** If the patient qualifies, staff should access drug replacement programs for underinsured cancer patients. These programs not only assist with infusion

drugs but can also help with supportive care regimens. For oncology practices, a well-designed drug replacement program is critical to the financial success of the infusion unit.

- **Ongoing communication.** Throughout the patient's course of care, trained staff members should manage communication between the patient, providers, billing department, insurance carriers, and assistance programs regarding all financial matters.

Commonly, medical oncology practices with a financial specialist role see less denied and rejected claims and bad debt rates due to patients accessing financial support programs and participating in payment plans.

Going Forward

Unique challenges exist for hospitals and health systems acquiring medical oncology groups. Before any purchase, hospitals and health systems should realistically assess the financial performance of the medical oncology group, given varying assumptions about volume, revenue, and cost. Ideally, this assessment will begin prior to acquisition, when the business model for the group is in initial development. Yet, the long-term success of the program is dependent on the careful monitoring of the issues identified in this article. 

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