CHARTIS BRIEFING:

Hospital and Oncology Physician Alignment

Why hospitals should prioritize cancer physician partnership amid COVID-19

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The United States cancer care ecosystem has been significantly disrupted by COVID-19, producing financial hardship and an uncertain future for many cancer centers and physician practices. In this environment, opportunities are emerging as independent oncologists seek new partners to secure longer-term financial stability or avoid more immediate service rationalization and downsizing. While hospitals may be reluctant to pursue these partnerships in a pandemic, medical oncology alignment represents a singular, and perhaps fleeting, opportunity to capture market advantage and materially improve the financial position of a health system.

In this briefing we highlight the **imperatives for oncology partnership**, and proven strategies for successful transaction and integration.

COVID-19 did not start consolidation…

The Community Oncology Alliance (COA) has tracked horizontal integration in the medical oncology space for nearly 12 years, with its most recent report identifying 925 practices acquired during that period. Importantly, the rate of acquisition has continued to accelerate in the past two years, with acquisitions from hospitals up 10 percent and larger practices/corporate entities up 21 percent.[1] Much of the latter can be attributed to the activity of OneOncology, a management company with $200 million in private equity backing from General Atlantic. Like its precursor, McKesson's US Oncology Network, the OneOncology team is busy acquiring practices across the country to bring drug purchasing scale, advanced analytic capabilities and innovation to business models and care delivery platforms.

The frenetic pace of oncology transactions is the byproduct of simple market forces:

Demand. Demographics and cancer incidence have produced a growth market for medical oncology and its logarithmically-increasing buy-and-bill drug prices.[2] That pharmaceutical spend is attractive to would-be aggregators like OneOncology, drug distributors like McKesson US Oncology, and those with purchasing advantages like PPS-exempt cancer hospitals and disproportionate share hospitals.

Margin Attractiveness. Hospitals are generally reimbursed more than practices by Medicare and commercial payers and can often buy cancer drugs at a 20 to 30 percent discount through the 340B program. Over 80 percent of COA-reported acquisitions have been by 340B hospitals, many of whom leverage these savings toward reinvestment in cancer assets and services.[3] These drug savings, combined with even modest commercial reimbursement advantages, typically produce $1.0 to $2.0 million of contribution margin per full-time equivalent oncologist in a hospital-based program. Further, aligned oncologists tend to provide indirect lift to other parts of the oncology service line, which accounts for 25 to 40 percent of total margin in many health systems.

Competition. As cancer programs seek to differentiate in increasingly crowded markets, many are pursuing integration to create competitive advantage. Oncologists are the cornerstone to integrated cancer care, providing not just initial treatment, but the bulk of longitudinal surveillance and management of patients in survivorship. Bringing these specialists into the hospital's care model, medical record circuitry and physical cancer space can produce profound shifts in patient experience and market preference.

Supply. The American Society of Clinical Oncology expects a shortage of over 2,200 oncologists by 2025 as demand outstrips supply by some 20 percent.[4] This scarcity is propelling intense competition in the labor pool for oncologists, driving up compensation and compelling cancer programs to build integrated cancer care through practice acquisition.

But further COVID-19 consolidation is inevitable…

We are beginning to see data on how dramatically COVID-19 has impacted cancer providers, including Flatiron Health's report of 270 oncology practices platformed on its OncoEMR. In this cohort, Flatiron observed a 40 percent drop in new patient visits between February and April, with a doubling of cancellation and no-shows.[5] Chemotherapy cancellations were modest, with 3 to 17 percent declines, but infusions are a trailing indicator relative to upstream diagnostics, surgery and oncology new patient consults. Most medical oncology practices carry multimillion-dollar drug inventories and live month-to-month on a cash flow basis, leaving very little room for volume or payment disruptions. Dr. Bobby Green, Flatiron's Chief Medical Officer, highlighted this financial reality in *The Cancer Letter*, confirming "There's a lot of financial concern that's out there right now about being able to stay open and keep the lights on."

Not all markets have independent medical oncologists, but for those that do, there are only a few possible outcomes for practices in financial distress:

1. **Restructuring**. The most extreme outcome could involve service rationalization and clinic or infusion site closures — a consequence most likely to materialize with smaller or solo-practice groups, oncologists approaching retirement or practices in rural settings without viable partner channels. With 435 clinics closed and another 350 reporting financial struggle in the past decade, a wave of COVID-19-provoked downsizing and restructuring is a real possibility.[1]

2. **Private Equity/Corporate**. Private equity-backed organizations represent a viable path for practices, evidenced by OneOncology's flurry of press releases during the past 90 days, including acquisitions with Ft. Worth's Center for Cancer and Blood Disorders, Tennessee Oncology, and New York Cancer and Blood Specialists. Similar activity occurred with 21st Century Oncology as it leveraged a $300 million investment from GenesisCare to establish joint ventures in Texas, Arkansas, Oklahoma and Missouri.[6] These deals were likely in advanced stage prior to COVID-19, so it remains to be seen how recent market turbulence will impact valuation multiples or the appetite of private equity in this space. Even PE-backed practices have not

been immune to the present challenge, with OneOncology's co-founder, West Cancer Center and Research Institute, reducing workforce by over 80 colleagues in early March.[7]

3 **Hospital Alignment**. Partnership with a local community or academic health system represents the most likely path for oncology practices. The barrier here, of course, is that many of these health systems are in their own states of financial tribulation, particularly in hot spots like the Northeast. Organizations with strong pre-COVID-19 balance sheets will be best positioned to seize market opportunities in oncology, but we do not believe this is a prerequisite. Our experience across numerous oncology transactions is that they are uniformly margin accretive, quicker to demonstrate return than many other types of practice acquisitions and important to prioritize — even if the health system's focus turns otherwise inward during recovery.

Transaction speed and know-how will be essential to partnership success

In markets with independent oncology, the acquisitive value will be obvious to many buyers, and it is therefore critical to engage quickly, leverage expertise, and expedite the transaction.

Engage Early. Many practices are losing cash quickly, and it may get worse before it gets better as COVID-19-induced diagnostic and surgical delays cascade through cancer's sequential value chain toward chemotherapy. This urgency should drive outreach to your independent oncology colleagues to understand their needs and, if appropriate, proffer quick exploration of partnership. Speed to engagement will also be required to be competitive with a faster and less risk averse set of corporate buyers in the post-COVID-19 marketplace.

Leverage Expertise. Oncology bears little resemblance to other types of practice acquisition and often stymies hospitals with otherwise mature transactional competency. Its economics are complicated at the intersection of clinic and chemotherapy, and its employment and contractual models are nuanced for that reason. Moreover, the oncology practice often comes with its own horizontally integrated ecosystem, requiring hospitals to transact on radiation therapy, diagnostic imaging and retail pharmacy as part of the deal structure. Modeling the value of these services is no simple exercise given byzantine site neutrality regulation and appraisal complexity. We recommend speeding the due diligence curve by engaging knowledgeable brokers to advance partnership design, legal counsel with transactional expertise and valuation professionals fluent in oncology.

Expedite the Process. Transactions often meander through multi-month exploration, non-binding term sheets and capital approvals. Distressed practices will not have this luxury of time, nor will hospitals be competitive with other buyers if legacy timeline constraints hold. Recent hospital lessons in mobilization for COVID-19 should be applied to new partnerships, empowering an agile team to speed the process of deal evaluation and execution. Rapidity will be essential not just to transaction close, but to the end point of integrating oncologists into the programmatic and financial fabric of the enterprise.

The pursuit of oncology partnership amid COVID-19 represents a path to financial recovery and advancement in the marketplace. If hospitals are attuned to the opportunity and quick to action, the product will be vision enabling, financially rewarding and edifying to cancer patient experience and quality — a worthwhile venture in an otherwise challenging time. ■

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