Strategic Options for Oncology Practices

Private Practice Outlook for 2006 & Beyond

by Mary Lou Bowers, MBA

Oncology practices have weathered two years of changes as implementation of the Medicare Modernization Act of 2003 (MMA) continues to unroll. During this period of adjustment to a new reimbursement methodology (average sales price, or ASP), new coding for chemotherapy administration, Medicare Part D, and more….your practice has heeded the advice of experts, taken steps to ensure practice efficiency, carefully monitored contracts, and provided staff education. Now, what? Despite an array of "unknowns" facing oncology private practices, you can still navigate a promising course for the future. Options include consolidation, "transformation," and diversification.

The starting point—regardless of practice size—is planning. Private practice physicians should begin by taking time to consider: 1) Why they chose to practice medical oncology in their current setting (small, medium, or large) and 2) what—if anything—they want to change about their situation. Physician planning must also include an income/risk analysis and goal assessment—both personal and professional.

Strategic business plans can be created to benefit every practice size—small, medium, large, mega. But these plans cannot be one size fits all. Solutions that work for larger practices are not necessarily feasible for smaller practices. As a foundation for planning, physicians should answer such questions as:

- Am I a team or solo player?
- Why did I choose to practice in this setting? And do I have an interest in changing the setting?
- How many hours a week do I want to work?
- How many years do I want to work?
- What are my retirement plans?
- What does my earning potential have to be?

Whether your practice is small—usually defined as three or less oncologists—or a large, multi-specialty group, sound, thoughtful, and long-range strategic planning will help your business survive our rapidly changing healthcare environment. Consider the following three strategic options with your practice and personal goals in mind.

Market Consolidation: It's a Small World After All

Oncologists who choose the small practice setting do so for a wide variety of reasons (e.g., a need for independence and control, quality of life, the desire to stay in a certain geographic region). Sometimes practice size is determined by forces outside of the physician's control. For example, practitioners who work in rural areas may serve a limited patient population in a region in which patient volume is unlikely to grow. Most likely then, these physicians work in smaller practices.

Physicians who work in small practices are often satisfied with their location and practice set-up. The problem is that these small, rural practices are often the first to feel the "reimbursement pinch." With smaller margins, these practices may have more difficulty weathering the effects of recent reimbursement changes. They must become skilled at negotiating the best drug prices.

In 2005, Medicare began using the ASP methodology to reimburse oncology practices for their drug purchases; it is likely that at least some private payers will follow suit. By definition, the ASP methodology means that some practices will purchase their anti-cancer drugs for less than ASP, while others are forced to pay *more*. Those oncology practices that are purchasing anti-cancer drugs at more than ASP will be in trouble and will need to find alternative solutions.

One option—depending on the practice's payer mix—may be participation in Medicare's competitive ac-

quisition program (CAP). See page 14 for more information about CAP.

Another option available to small oncology practices is market consolidation, which is essentially a payer-contract strategy. A carefully-planned and executed consolidation strategy can allow physicians from a wide geographic area to band together with other practices in different areas to cover a larger region. Once consolidated, these practices then have increased leverage for payer contract negotiations. Consolidation also improves their ability to negotiate drug purchase prices.

On the positive side, practices that are proactive in investigating the possibilities of consolidation may fare better than practices that do nothing and end up getting squeezed out when other groups consolidate around them. Simply put: consolidate before the market consolidates without you. On the other hand, practices must also be aware of the possibility of insurers waving the anti-trust flag in front of any practices they perceive as getting too "large" and too powerful in negotiating contracts and prices.

Practices who choose market consolidation may find that it is an easier option than a joint venture or merger strategy. (In mergers, physicians must have the same pay classification, must get paid the same way, must practice the same way, and must have the same overhead.) If physicians do their homework (see box on page 28), consolidation is also less expensive than joint venturing or merging. On the other hand, practices that don't do their homework may find that consolidation can cost much more.

Consolidation is not top-down management. Rather, a consolidation agreement is more like an "umbrella" over a group of practices that allows physicians to continue to practice the way they want. Consolidation can take several forms, such as several medical oncology practices coming together or perhaps one or more oncology practices merging with a group of radiation oncologists. In this second scenario, the practices are also able to diversify their business by offering several different product lines. (See "A Consolidation Story" on page 30.)

Even now, three states—Florida, Georgia, and Tennessee—are experiencing market consolidation in the oncology marketplace. Practices are choosing market consolidation because their payers are regional and physician alignment allows them to dominate the market and increase their negotiating power. With some practices consolidating or aligning to mimic payer regions, the marketplace is even seeing consolidation across states.

Some small oncology practices may want to consider merging with or into a multi-specialty practice or getting out of the infusion business altogether and merging with a local hospital. Of course, practices that choose either of these two options may also need to accept lower income potential.

Another option for small practices is to join a national group, such as US Oncology, which offers management services for oncology practices. Under this strategy, phy-

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sicians give up control of certain aspects of their practice in exchange for certain established benefits and services.

Transformation: Become a "Dispensing" Practice

Today's oncology practices must decide if they are going to continue to provide anti-cancer drugs to patients. If the answer is "yes," then practices need to think strategically about their drug purchasing decisions. Will the practice participate in CAP? If so, will brown-bagging become an issue? A new wrinkle in the brown bagging saga may already be underway as some commercial payers

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Dispensing Model: One Practice's Experience **by Amanda Patton**

Broome Oncology is a medical oncology private practice located in upstate New York. The seven-physician practice has two sites with four physicians and a nurse practitioner at one site and three physicians at a second site. The practice employs about 30 nurses. With a lab at each site, the practice has two pharmacists, including a pharmacist board certified in oncology pharmacy, several phlebotomists, and three pharmacy technicians.

The busy practice sees about 100 patients per day and, of those, about 40 receive treatment each day. The practice's payer mix is more than 50 percent Medicare with 90 percent of these patients having some type of secondary insurance. The remainder are largely private payers and a very small number are Medicaid patients.

In November 2005, the practice became a dispensing physician practice. For this practice, the decision evolved from a presentation sponsored by the practice's group purchasing organization (GPO). After hearing about the dispensing option, the practice's pharmacist and physician leaders discussed whether it made sense for their practice.

Broome Oncology views the addition of dispensing primarily as an added benefit for patients that would make a modest return on a relatively small investment. Because their pharmacists were already carefully managing the practice's drug inventory, these professionals played a key role in the decision-making process.

Getting Off the Ground

Broome Oncology contracted with Physician's Total Care (PTC), one of several companies nationwide that help practices with the dispensing physician model. For a relatively small investment (the pharmacy software cost about $1,500, plus a comparatively inexpensive monthly support fee, and the investment for drug inventory for those drugs purchased through PTC), the practice implemented the dispensing physician model.

Patients are very happy with the convenience, said pharmacist, Hana LoPiccolo, RPh. Not only is the care process streamlined, but dispensing the supportive care drugs in the practice setting allows Broome Oncology to provide additional patient education about the drug, something the practice has more experience with than a retail pharmacist might, LoPiccolo said.

Working with PTC, the process of becoming a dispensing physician practice took about two to three months. LoPiccolo credits PTC with doing an excellent job of taking care of the administrative requirements, including the time-intensive process of getting registered with payers and related paperwork. The practice is able to participate with all but a few of its plans.

Early on the practice made the decision not to carry a wide variety of drugs. "For an oncology practice, it makes sense to keep the inventory low and find what drugs you use the most," said LoPiccolo. This practice uses the dispensing model primarily for supportive care drugs, including antiemetics that often must be given to patients either immediately before or after chemotherapy. The practice chose not to expand its inventory and does not stock pain medications, for example.

In terms of the practice's work processes, the change has been minimal. Basically, the practice added a few shelves for the drug inventory. This practice does not

begin to move certain drugs from medical benefits to pharmacy benefits. Physician offices that do not participate with pharmacy benefit plans will lose the revenue from these drugs. For example, based on 2004 CMS claims data, if growth factors transition from medical benefits to pharmacy benefits, oncology practices may lose up to 30 percent of their drug revenue. This move would mimic what could happen under Medicare in 2006 for those beneficiaries who choose to participate in the Part D drug benefit.

Another issue affecting drug delivery in the office setting is that cancer care is increasingly moving toward oral drugs. Currently about 25 percent of oncology drugs are oral, and oral drugs represent approximately 35 percent of all anti-cancer drugs in the pipeline, according to Michael Reagan, RPh, of the International Oncology Network (ION).

Practices that want to be a full-service pharmacy must understand and participate in Medicare Part D. Even more important, the practice must qualify as an "in-network" pharmacy for the Part D plans. Most dispensing pharmacies pay third-party entities to complete all the necessary paperwork to clear the practice to dispense drugs. These companies go to each plan and each insurer that the practice deals with and work out an arrangement so that the practice can dispense and be reimbursed for the anti-cancer drugs it provides to patients. Practices that want to open an in-house, retail pharmacy must go to each plan directly to request that insurers include the practice's pharmacy in their coverage.

Be aware that some states, including Massachusetts, Montana, Utah, and Texas, have passed legislation banning dispensing physicians. Therefore, practices in these states only have the option of establishing an in-house retail pharmacy.

Practices that adopt a dispensing physician strategy will dispense drugs through the physician's license. Many major insurers will reimburse these services, *if* the physician's office uses the correct billing system for claims processing. Currently, practices can purchase these systems from three vendors: Allscripts, Physicians Total Care, and ION. The systems average about $6,000, including software and start-up costs. Practices that transition to a dispensing physician model may anticipate between a two to nine percent return on their investment.

Diversification: A Tree with Many Branches

A diversification strategy has the potential to limit and/or drive down the total percent of practice revenue that comes from drugs—leaving practices less vulnerable to the ever-changing drug reimbursement landscape. For medium to large oncology practices, a diversification strategy may actually *increase* revenue streams.

One popular diversification strategy for practices is the addition of imaging services. Before investing in expensive equipment, staff, and training, however, practices should consider the increased payer scrutiny being directed towards imaging services. According to

Two More Long-term Strategic Options for Oncology Practices

1. Merge your practice into a multi-specialty practice or hospital or a national management company.

2. Stay small and accept that you are likely to see reductions in market share and profits.

include a full-fledged retail pharmacy, so they can't fill every prescription.

Here is how the dispensing element of the practice works. The practice pharmacist receives the prescription and obtains pre-authorization for the drug if necessary. The pharmacist then puts the order through to the insurer (payer) using the PTC software. The order is viewed by the insurer just as if a pharmacy were putting through the order. The money exchange works just the same as a retail pharmacy in that the practice submits the prescription order to the insurer, the insurer makes the payment, and then the doctor's office collects the patient's copay. PTC has no role in the transaction.

Not a Panacea

So far the dispensing physician model is working well for this practice; however, LoPiccolo has some caveats. First, she points out that the fact the practice already employed pharmacists and pharmacy technicians is key to their success. She cautions that practices should not expect to ask a nurse to put these prescriptions through the health plans. Having retail pharmacy experience is important in understanding both the software and the terminology involved in working with the payers in this arena. Second, a pharmacist has the skill set to carefully manage a practice's drug inventory. Third, practices may face longer delivery times for drugs purchased through companies offering dispensing programs. According to this practice's pharmacist, incorporating a dispensing physician model into a practice is best suited for practices with a pharmacist or, at least, a pharmacy technician on staff.

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2004 CMS claims data, nearly 30 percent of all healthcare increases in the past year occurred in imaging.

Starting in 2006, PET imaging was termed a "designated health service." Under Stark laws, this classification means the imaging equipment must be wholly owned by the practice—no more joint ventures. With the final budget bill for 2006 mandating payment reductions for diagnostic services, practices must carefully evaluate *all* radiation oncology services before making any strategic decisions. Oncology practices also need to be aware that, unlike medical oncology, radiation oncology is capital intensive. It's also technology that is rapidly evolving so that today's cutting-edge PET or CT equipment may be outdated within five years. Realistically, only larger practices (seven physicians or more) are likely to generate the necessary patient volume to sustain the addition of imaging services, such as PET or CT.

In addition to imaging, practices may want to consider adding supportive care services or a nutritional component. While Medicare does not reimburse for supportive care services, some private payers do. Patients appreciate supportive care services, such as yoga, art therapy, massage therapy, and specialty boutiques that provide items such as wigs. Plus, these services do not carry a high price tag for the practice. Adding a dietitian experienced with the special needs of cancer patients benefits your patients and can help set your oncology practice apart from the competition. Larger practices may want to bring the social worker or dietitian on staff, in which case the practice can bill for services under a bill-for-service model. Smaller practices may want to lease space to such specialists or negotiate terms for adding these specialists on a part-time basis.

Consolidation Homework Assignments

Oncology practices that are considering market consolidation need to work out their business terms *prior* to bringing in attorneys. Business terms can include:

- Thelength of the consolidation agreement
- Amethod for letting individual physicians out of the agreement
- Amethod for adding new physicians to the agreement
- Alist of any capital expenditures that will be jointly purchased by all parties
- Aplan for how the fee structure will work
- Anychanges in payer contracts
- Strategicplans for common areas, such as a diagnostic or radiation center
- Apolicy for how individual operating costs will be expensed
- Awritten profit-sharing plan.

A Look into the Crystal Ball

Competitive Acquisition Program

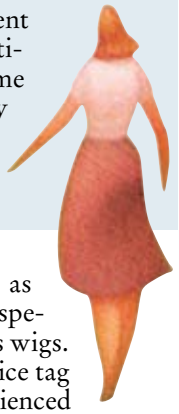
Practices that cannot purchase their anti-cancer drugs at or below ASP have the option of participating in Medicare's Competitive Acquisition Program (CAP) slated to start July 1, 2006. The final CAP rule stated that vendors can "contract" with physician offices to collect patient copayments; however, legal barriers exist in terms of how that contract can be written. For example, contracts cannot be on a volume or per patient basis. Still, these contracts may be a way for practices to re-coup some of the drug revenue they lost when switching to the CAP program.

Pay-for-Performance (P4P)

The quality care movement is the next big frontier. In 2005, CMS established an oncology quality of care demo project aimed at measuring how cancer *patients* were doing. In 2006, a newly-revised oncology demo project is measuring quality of care in terms of how *providers* are doing. In 2005, the demo was aimed at nurses and administrators. In 2006, physicians must be involved in the demo project by documenting 1) the cancer diagnosis, 2) the stage of disease, and 3) whether the treatment regimen follows commonly accepted treatment guidelines. (If not, physicians must provide their rationale for making a different treatment decision.) It is likely that most physicians will adhere to accepted clinical guidelines rather than have to explain a different course of action.

Part D and Patient Assistance

In 2006, the Medicare Part D prescription drug benefit will be a huge issue for oncology practices and their patients. One significant issue for oncology is that—due to a technical legal loophole in the final rule—patients with Part D will *not* be able to qualify for pharmaceutical patient assistance programs, which provide anti-cancer drugs free of charge. In fact, some pharmaceutical companies have already closed their patient assistance programs.



Once your practice has a business plan in hand,
call in legal representation to finalize the financials and the business terms.

Choosing the Right Model

In the context of the practice goals identified, consider whether a consolidation, diversification, or dispensing physician strategy would be a good fit for your practice. If the decision is made to explore one of these business models, practice administrators and physicians must work together to develop a pathway toward the chosen strategy.

In this pathway, you will need to identify *who* your practice will need to work with, such as another medical oncology practice or a radiation oncology practice. Call these individuals and/or groups to determine their interest in consolidating or diversifying services. If mutual interest exists, the next step is to hold a face-to-face meeting with the interested parties.

At this point, your practice may want to consider using an experienced oncology consultant to facilitate the meeting and to begin defining the business terms of the agreement. (Keep in mind that working with oncology consultants will cost you less money in the long-run than working immediately with attorneys.) Your practice can work with consultants to determine the financial numbers needed in order to successfully adopt the new business model. Then your practice can begin developing a business plan for its consolidation, diversification, or dispensing physician strategy. Once your practice has a business plan in hand, call in legal representation to finalize the financials and the business terms.

Today's oncology practices must think outside the box. Many practices have the staff and tools to strategically plan for a successful future; don't be afraid to try an option similar to the ones discussed in this article. While there is no "one size fits all" solution, making no decision and allowing your practice to drift with the tides of change *is* making a decision. If your oncology practice is to thrive in 2006 and beyond, know your options and don't be afraid to make changes.

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More Puzzle Pieces: Pay-for-Performance and EMRs

Under the MMA, Medicare is increasing the involvement of commercial insurers in cancer treatment. (The Part D drug benefit is a good example of this new "partnership.") So, practices *must* pay attention to their commercial contracts and commercial payer trends. Even more, practices must understand their current payer mix and what the future may hold.

For example, one payer trend is already underway—pay-for-performance (P4P) quality care measurements. Today, some oncology practices are making key capital resource investments in this arena, such as purchasing electronic medical records (EMRs) and other medical information systems. Beyond the well-documented benefits of improving practice efficiency and streamlining workflow, EMRs also hold promise for improving patient care by reducing medical errors. Additionally, practices that invest in such new technology will be able to generate outcome data that will let them participate—and hopefully benefit from—the various P4P programs. These practices will also be able to demonstrate patient compliance, which is what insurers are interested in seeing.

Unfortunately, many oncology practices are hesitant or even unable to commit the money, time, and resources required to transition to an EMR system. But help is on the horizon.

In 2005, the Office of the Inspector General (OIG) of the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) separately published proposed regulations in the *Federal Register* to help ease the transition to EMRs and e-prescribing. Specifically, these rules were designed to allow hospitals and other entities to donate items and services, such as hardware, software, and training, to healthcare providers without violating the federal anti-kickback law and the physician self-referral law ("Stark Law").

Several conditions must be met to qualify for this new anti-kickback safe harbor for e-prescribing. Perhaps most importantly, all donated items and services must be "necessary" and "used solely" to receive and transmit electronic prescription information. In other words, the safe harbor does not allow donated equipment and software to be used for anything other than e-prescribing. (For more information about this safe harbor, go to CMS website at *www.cms.hhs.gov* and "Legal Corner" in this issue, page 21.)