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Highlights from the ACCC Fall Leadership Conference

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HIGHLIGHTS FROM THE ACCC FALL LEADERSHIP CONFERENCE

ACCC Explores Reimbursement Initiatives/ Uniform Legislation

The major focus of the Association's reimbursement initiatives will be to explore the "potential for developing uniform state legislation to ensure adequate reimbursement for state-of-the-art cancer care," said ACCC Executive Director, Lee E. Mortenson. According to Mortenson, the key issue that must be examined is how broad such a bill should be. "We would prefer to take a position that encompasses off-label usage, investigational therapy, and related medical costs that would apply to all drugs for all diseases." However, Mortenson maintained that "we must be realistic and develop fallback positions, such as limiting coverage to drugs used for life-threatening conditions or, if all else fails, addressing only those agents used for the treatment of cancer and AIDS." Moreover, "obtaining coverage for experimental therapies and related medical costs might be tough," Mortenson said. "Such therapies and services must be clearly defined." Mortenson also pointed out the need for collaboration with a variety of parties, including state societies, to ensure that the legislation developed "can be sponsored in any state."

Other ongoing ACCC initiatives include the development and promotion of a patient brochure that discusses current cancer reimbursement problems and the need for patients and their families to examine current insurance coverage language. The Association is also examining the possibility of sponsoring regional reimbursement workshops in major cities across the nation.

Legislative Update Focuses on Medicare Cuts

Although the budget process was stalled at the time of ACCC's Fall Conference, it is doubtful that there will be any change in the proposed Medicare cuts on the provider side of the equation, according to John S. Hoff, Swidler & Berlin, Washington, DC.

John Hoff

"The days of government using the Prospective Payment System as a way to 'cut the budget' are coming to an end"

Hoff explained that the proposed cuts include a freeze on physician fees at the 1990 levels, although "there will be an update for primary care physicians;" a market basket adjustment of 4.1 percent under Medicare Part A for 1991, "which will be further reduced by .75 percent in 1992;" reductions in durable medical equipment payments; a decrease in the fee schedule for clinical labs; the end to return on equity for proprietary hospitals; and a decrease from 7.7 percent to 6 percent in the adjustment for indirect medical teaching costs.

Hoff contended that government must begin to address Medicare's "structural issues," noting that the days of government using the Prospective Payment System (PPS) as a way to "cut the budget," are coming to an end. "They are realizing they can't get any more dollars out of PPS," Hoff said, noting that prior to the above proposed cuts, "one-half of the nation's hospitals were already losing money on Medicare patients."

Another issue of concern that Hoff highlighted was the passage last year of anti-dumping legislation. The legislation prohibits hospitals from "delaying examinations in the emergency room to ask patients about their insurance coverage," Hoff said. Hospitals must also "maintain a list of on-call physicians available to help stabilize patients." Finally, and of particular importance to cancer centers, Hoff explained that "hospitals can no longer refuse to accept transfers to specialty units if they have the capacity to treat those patients." As a result, he warned, "specialized cancer centers may find themselves the recipients of increased dumping by general hospitals."

Speakers Address Coding, RBRVS Issues

A number of issues concerning the introduction of a Resource-Based Relative Value Scale of Payment for physicians that have yet to be resolved could have a significant impact on the practice of oncology, according to Terry Coleman, counsel to the law firm of Fox Bennett & Turner, Washington, DC, and former Deputy Administrator of the Health Care Financing Administration (HCFA).

An area of particular concern will be the revision of visit codes, Coleman said. "The AMA and the Physician Payment Review Commission (PPRC) are developing uniform interpretations of physicians' evaluation and management codes (EM codes)." Because such elements as severity of illness, counseling, and the time it takes to deliver a service, are expected to be included, "it is possible that the new codes will allow a higher level of service and be more conducive to the practice of oncology," Coleman said. "But how the codes are defined and whether they are sufficiently defined will be a major issue for oncologists."

Coleman explained that one of the goals of the new HCFA Administrator, Gail Wilensky, Ph.D., is to ensure that there is "less variation among Medicare carriers" in their payments for services and

"more uniform services." In fact, Coleman said that it is HCFA's goal to "eliminate all local codes," which would affect some chemotherapy administration fees.

Terry Coleman

"It is HCFA's goal to 'eliminate all local codes,' which would affect some chemotherapy administration fees"

Joseph Bailes, M.D., Chairman of ASCO's Clinical Practice Committee, said that in ASCO's discussions with HCFA, the Agency "has been sympathetic with the fact that chemotherapy administration is more than just a hospital visit. The problem is when does the visit end, and administration management begin?" Bailes believes that the implementation of a relative value scale of payment will "probably resolve this issue." Furthermore, he said that the "concept of management codes will allow a carve-out for oncology," and that they are "probably the long-term solution" to current coding difficulties.

However, as we slowly move to the RBRVS payment system, Coleman pointed out severe difficulties with the data being used, geographical distortions, and the calculation of practice costs and malpractice components. For instance, he said there is a danger that "oncology practice costs may be lumped in with internal medicine. If oncologists' overhead charges are higher, they will be at risk of having their costs underestimated." Another concern is the potential for geographical distortions under a RBRVS system. It is expected that RBRVS will have "dramatic geographic effects," Coleman said. Preliminary data suggest that payments will range from as much as a 40 percent increase for physicians in rural Missouri, Alabama, Iowa, and Utah, to a 27 percent decrease in payments to physicians in Manhattan, NY. Moreover, Coleman said the geographic factor for practice costs will be based on "1980 census data, including staff salaries, medical supplies and equipment, office rents, malpractice insurance costs, etc."

As far as the release of relative values for physician specialties, to date, "specialty societies seem to agree with Hsiao's values," Coleman said. One exception, he said, are thoracic surgeons which, based on preliminary data from Hsiao's group, could experience approximately a 26 percent cut in payments. As a result, they are conducting their own survey for submission to HCFA but, according to Coleman, it is uncertain if HCFA will accept those data.

The relative values for oncology are due to be released by Hsiao within the next few weeks. Bailes noted that if ASCO disagrees with Hsiao's data, "we will probably take the route of the thoracic surgeons and conduct our own survey." However, Bailes said that first the Society would "want to know if HCFA would accept their survey data or not."

Coleman provided preliminary estimates of the effect of Hsaio's relative values on other specialties, including internal medicine (+12%), general surgery (-4%), general practice (+34%), radiology (-20%), and pathology (-19%).

Nurse Recruitment, Retention Strategies

Hospitals need to develop creative compensation and benefit policies, experiment with new patterns of staffing and task assignments, and provide programs and benefits that fit current demographics, if they are to successfully recruit and retain oncology nurses, according to Chris Miaskowski, R.N., Ph.D., the School of Nursing, the University of California, San Francisco.

Miaskowski presented data from a 1989 Commonwealth Fund Survey of the nursing profession as a whole, which showed that the most important job-related factors to nurses are 1) scheduling, 2) salary, 3) benefits, 4) commuting, and 5) job stress. On the other hand, a 1989 national survey of community hospital-based nurses by the Oncology Nursing Society showed a 13.5 percent turnover rate; a 12.1 percent vacancy rate; small salary differentials between entry-level nurses and nurses with 10 years of experience (12.78 vs. 15.78); and low differentials for nurses working evening and night shifts vs. day shifts (+1.10 for evenings and +1.53 for nights)."

These are the facts we must think about in terms of retainment issues," Miaskowski stressed. Innovative policies and benefits that relate to nurses' prioritization of job-related factors are needed, she contended. Moreover, although the Commonwealth Survey found that the majority of nurses are married and have children, the ONS survey found that only 24.7 percent of institutions offer self scheduling, and only 26 percent provide child care services.

Miaskowski suggested that hospitals develop the following strategies for improving nurse recruitment and retention: offer adequate salary differentials for shifts; institute flexible scheduling; adjust nurses' daily routines; develop creative compensation policies, such as "cafeteria plans" of benefits; attract part-timers by providing salary and benefit incentives; create career ladders that are linked to compensation; establish child care programs; experiment with new patterns of staffing and task assignments; and invest in labor saving devices and equipment (i.e., computerized medical records and computerized bedside treatment management systems).

Carbone Recipient of Clinical Research Award

Paul P. Carbone, M.D., Director of the Clinical Cancer Center, University of Wisconsin, and Project Chairman of the Eastern Cooperative Oncology Group (ECOG), was the recipient of the Association's Clinical Research Award for his contributions to the advancement of community-based research.

In accepting the award, Carbone urged medical oncologists to become involved in prevention trials, such as the proposed NIH Phase II study of tamoxifen as a chemopreventive agent. Citing the increased incidence of breast cancer (140,000 cases per year), the number of deaths (40,000 per year), and the lack of significant change in overall mortality, Carbone maintained that physicians

"should not just be interested in treating patients with high-cost, high-tech treatments, such as bone marrow transplantation. We need to concentrate on what causes cancer and to devote resources to the prevention of carcinogenesis."

Paul Carbone

"We need to concentrate on what causes cancer and to devote resources to the prevention of carcinogenesis"

Acknowledging that prevention studies are a "challenge to medical oncologists," because they are larger studies and they last longer, Carbone urged oncologists to meet that challenge. "It is my belief that it is possible to prevent cancer. I want to see oncologists involved in such trials." According to Carbone, if the NIH reproduces current safety data, the tamoxifen trial will treat 16,000 high-risk women at about 10 centers, and include a five-year follow-up period.

Carbone's contributions to clinical research include the development of active combination chemotherapy for Hodgkin's disease, non-Hodgkin's lymphoma, myeloma, breast cancer, and the clinical testing of new therapeutic agents.

Due Diligence Key to Joint Ventures' Success

Proper due diligence can help avoid the most common reasons why as many as 6 to 7 out of every 10 joint ventures fail, according to Marc Gelinas, Vice President, LSG Consulting Services, Inc., Colleyville, TX. According to a survey by *Modern HealthCare*, most joint ventures fail because the partners didn't "do their homework, develop a decent business plan, scrutinize the business plan sufficiently, or the partners did not have enough experience," Gelinas said.

There are "two types of due diligence: legal—a careful review of any documentation having an effect on a joint venture (i.e., contracts, loan agreements, etc.); and financial—the investors' review of the proposed partners, the management, the structure of the business, and the services it will provide," Gelinas explained.

Generally, it is the investor who performs due diligence reviews after the development of a comprehensive business plan," Gelinas said. However, "in hospital-physician joint ventures, you may want to bring in a consultant to review the business plan, or a third-party investor," because of the difficulty of the joint venture partners, in essence, reviewing their own own business plan.

Gelinas outlined the type of issues that due diligence reviews must include in the review of the joint venture partners and players. In the case of the hospital, physicians need to examine "its reputation in the community; its financial strength (can it support new programs and continue the quality of existing programs?); board, management, and staff relations (are they collaborative and cooperative or adversarial?); and its overall sophistication (is it considered to be leading edge, with quality staff and new technology?) In terms of hospital management, its experience, tenure and longevity, its attitude toward physicians, and its level of integrity all need to be scrutinized, Gelinas noted. "You must analyze not only the CEO, but the general counsel, the CFO, the marketing and public relations staff—in short, everyone who will be involved with the joint venture," he warned.

On the flip side, hospitals, in the case of a cancer program, should scrutinize not only the overall medical staff and its support of and opportunity to benefit from the joint venture, but the oncology physicians and medical director in particular. "The hospital should examine their clinical reputation, qualifications, leadership ability, reputation in the community, and their level of influence over the medical staff as a whole," Gelinas said. For instance, "are they willing to accept an outside medical director who has the proven leadership ability to make the cancer program successful?"

In the final analysis, "it is important that the hospital and the physicians view the joint venture as an equal partnership; a sharing of both the benefits and the risks," Gelinas stressed. To that end, there are common motives and objectives for the formation of a joint venture, including "to protect market share, to increase market share, to increase patient revenues, and to decrease costs," he pointed out.

New Models for Hospital-Physician Joint Ventures

There are some innovative joint venture models that are still being examined, but may better meet the needs of physicians and hospitals than traditional structures, according to Douglas Mancino, Partner, McDermott, Will & Emery, Los Angeles.

Douglas Mancino

"All players must have a risk... This is a key factor in passing fraud and abuse regulations"

One model that Mancino mentioned is called "swing space," and may meet the needs of medical oncologists who "don't want to become hospital-based physicians." In this model, the hospital's chemotherapy outpatient care area is operated as private physician office space during the day, and reverts to hospital-controlled outpatient space at night. According to Mancino, such a model has "not yet reached the implementation stage," because of various concerns it presents. For example, who is responsible for infractions? Do nurses shuffle back and forth between physician/hospital employment, which would involve multiple W-2s, or are they 100 percent either physician or hospital employees? And, what if the

treatment of a patient runs over the allotted time in which either the physician or the hospital is in control of the space?

Another unproven, yet innovative model that Mancino discussed is known as "divided space." In this model, physician- and hospital-controlled chemotherapy areas are located adjacent to each other. According to Mancino, "it appears that such an arrangement would comply with state licensing requirements." However, there are other issues concerning life safety codes, "particularly if you have substantial inpatient use of those areas," he said, as well as how to ensure proper entries into medical records, and, perhaps most importantly, how to overcome the perception on the part of patients that they are "receiving two bills for the same service."

Despite such unresolved issues, Mancino urged physicians and hospitals that are exploring various joint venture opportunities not to "overlook creative, transitional structures and relationships." However, Mancino stressed the importance of abiding by fraud and abuse regulations in the formation of any joint venture. "All players must have a real economic risk," he said. "This is a key factor in passing fraud and abuse regulations. The investors must divide the profits and the losses proportionate to their investment."

Contracting Between Hospitals and Physicians

Hospital/physician contracting can provide mutual advantages for both parties, as well as the patients served, according to Carol Miller, Senior Project Manager, ELM Services, Inc., Rockville, MD. Those gains include, "improved quality of care, a collaborative working relationship, convenience for patients and physicians, centralization of the oncology service, enhancement of the oncology product line, increased revenues, and decreased financial headaches for physicians."

However, negotiating such a contract entails, as a first step, that the "hospital and physician agree to forming a closer working relationship," Miller said. "There needs to be a careful review of office and hospital expenses and revenues." The two parties "need to determine what the base rate will be for the physician's professional services. Both parties must be willing to negotiate rates based on a fair market value," she stressed. They also need to determine "the threshold for, and the basis of, incentives. And the incentives must be achievable," Miller warned. Miller also said that "the contract never can be based on the number of patients/referrals; review must be tied to the service rendered." And both parties need to be aware of current legal issues, such as what is considered illegal remuneration under the Stark legislation, fraud and abuse regulations, antitrust laws, and other state and federal regulations.

Finally, Miller recommended that the oncology program be governed by members of both the hospital and the physician group, including budgeting, planning, equipment and technology acquisition, and staffing.

Despite the above challenges, Miller said that a contractual relationship can prove more rewarding than traditional models, such as private practice, an office lease on hospital premises, or physicians as employees of the hospital.

The Future of the Biotech/ Pharmaceutical Industry

There is a major opportunity for breakthroughs in the 1990s in oncology and AIDS treatments from the pharmaceutical and biotechnology firms, predicted Daniel L. Korpolinski, President, Adria Laboratories, Columbus, OH. Currently, Korpolinski said that there are 90 pharmaceutical products in the pipeline in the area of oncology and 45 biotechnology products.

However, Korpolinski also noted the increasing pressures on the pharmaceutical industry, including shorter patent periods due to lengthier drug reviews by the FDA, providers' increasing difficulties in obtaining adequate reimbursement from managed care plans and other third-party payors, and a greater loss of market share to generic drugs.

Daniel Korpolinski

"The traditional way of doing business is disappearing. We are all challenged to keep abreast of new technologies"

As a result, Korpolinski predicted a higher rate of consolidation within the industry and, in particular, between pharmaceutical and biotechnology companies. The smaller biotechnology companies "need the resources of the larger pharmaceutical firms to bring their products to the world-wide market as quickly as possible," he said. He also pointed to the need for greater collaboration between industry, nursing, physicians, hospitals, and patients. "The traditional way of doing business is disappearing. We are all challenged to keep abreast of new technologies," he noted, predicting greater collaboration between research and development staff in industry and physicians and researchers. ■