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Highlights of ACCC's 10th National Oncology Economics Conference

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Highlights of ACCC's 10th National Oncology Economics Conference

For the 350 conference attendees who gathered in San Francisco, California, on September 10-14, 1993, the fog surrounding the impact of managed care on oncology lifted to reveal not bright skies, but rather unsettled weather ahead.

The consensus of presenters at ACCC's 10th National Oncology Economics Conference is that ready or not, change is coming. If practices and programs are to survive this age of health care reform, they must carefully track costs, become customer oriented, and evaluate opportunities for alliances.

MANAGED CARE, EVERYWHERE

Although President Clinton has announced details of his reform package (see Capitol Comments, page 21), major health care reform will probably not be passed by Congress until well into 1994, and the final version may be smaller in scope than is currently being discussed. However, a number of states, including Florida, Minnesota, Oregon, Washington, and Kansas, have already started to take significant initiatives to create their own versions of health care reform. Insurance companies, providers, and hospitals are starting to self-reform.

Donald Jewler is Managing Editor of Oncology Issues.

by Donald Jewler

"It is all driving us toward one goal—managed competition," said presenter A. Collier Smyth, M.D. Managed competition creates powerful purchaser pools under which lie a delivery network of accountable health plans (AHPs). Within each AHP will be positioned an insurance administration, one or more hospitals, and a defined group of physicians.

As managed competition begins to evolve, the focus is on price, with discounting for services, explained Smyth, who is President of the Northern New England Clinical Oncology Society and a member of the American Society of Clinical Oncology's (ASCO) Clinical Practice Committee. Later, access, or how to limit access, becomes the focus. This is where the insurance company takes the reins and tries to control utilization through gatekeepers, second surgical opinions, and case management.

The next step in the evolution of managed competition, according to Smyth, is extensive capitation contracts. Instead of the insurance companies carrying all the risk, they will pass the risk on to the provider groups and hospitals in a capitated contract with deductibles, utilization review, and quality assurance.

Managed care networks will be organized to enhance cost-effectiveness. "Insurance companies are already organized, and hospitals are aggressively trying to organize. Each speaks with a single voice, and each has data on costs," said Smyth. "Physicians, however, are generally disorganized, having multiple interests and poor understanding of their costs." Organizing physicians, according to Smyth, is akin to "trying to herd cats."

Nevertheless, physicians will have to change their ways in this brave new world of health care reform, because oncology practice networks are a basic premise for negotiations with health alliances. Regional and national networks for primary care, multispecialty, and specialty groups are likely to form rapidly.

"Organization," said Smyth. "That's the only way physicians will be able to maintain a leadership role, not only in how medical care is practiced but also in the business aspect of medicine."

Already, primary care physicians are integrating. Hospitals are buying up primary care practices. HMOs are going out and buying up practices. Oncologists from around town are starting to merge.

"There is a mad rush to integrate services," said Smyth.

CONTROLLING COSTS IN A NONTHREATENING WAY

"As costs are ever more ratcheted down, it will be essential to have an idea about what aspects of a practice

are profitable or not, and how to adjust those individual areas," said John B. Benear, II, M.D., of Hematology-Oncology Associates, Inc., in Tulsa, Okla. He suggests that cost analysis will be essential in maintaining the viability of a practice and that the ability to match clinical data with cost data is vital. "Practices will be forced to generate data internally or be vulnerable to external monitoring and the errors of misinterpretations of that process."

Increasingly, practices and programs will be required to track costs of each evaluation and management service, chemotherapy regimen, and physician-performed diagnostic procedure, as well as physician and nurse time. Each drug and change in dose or schedule will be evaluated based on its cost-saving potential.

"Simply analyzing coding or examining costs for individual diagnoses is a nonconfrontational way to begin the process of educating and motivating physicians to practice in a manner that is both ethical and potentially cost effective," said Benear.

However, he added, introducing the issue of cost effectiveness may be difficult in some practices because some providers feel that cost effectiveness is not a part of the provider's relationship with the patient.

For almost a year now, administration at the Regional Cancer Center in the Memorial Medical Center, Springfield, Ill., has been working with its physicians, as well as its staff, to measure and reduce costs in a nonthreatening way. At the same time, the Center is striving to maintain quality, enhance operational efficiencies, and improve profitability.

"Our objective was to reduce oncology costs 10 to 25 percent over a nine-month period," said presenter Teresa D. Smith, R.N., B.A., M.S.N., administrator at the Memorial Medical Center. There, the Clinical Resource Management Program uses Clinical Information Financial System (CIFS) data to track costs of providing care. Data are collected on each physician and then compared with data from peers in the same hospital and in other hospitals of like size.

After helping to reduce cardiology costs by $1.7 million, the project was moved into the Regional Cancer Center, beginning with the medical oncologists. The first step was to identify three to five high-cost, high-volume DRGs and then begin detailed cost analysis. (DRG 410, chemotherapy, was the highest cost.)

"We sit down with the physician every three months and are able to show data for a particular DRG. We also provide comparison data from other hospitals," said Smith. She emphasized that all data are confidential, and each physician is given the time and opportunity to express concerns about any findings. "We don't want to overwhelm the physicians. Our goal is to help them in problem solving." In a short period of time, the program was able to reduce length of stay for DRG 410 by half a day.

General data are shared with a committee made up of administrators, department directors, physicians, and anyone else who deals with cancer patients, including lab staff, nurses, and the admitting unit. An operational plan is assembled for all the changes that have been identified.

"For a utilization management program to be successful, it must educate not just physicians, but also staff and managers. Everyone needs to understand the process and what the outcomes of the process will be," said Smith.

MARKETING YOUR PROGRAM AND SERVICES

Many of the changes coming down the road, said health care marketer Eric N. Berkowitz, Ph.D., have nothing to do with "where you have dedicated most of your lives, the clinical area. They are primarily driven by information systems. How good is your information system, your financial system? ... Do you know your cost per unit of delivery?"

BLUES FOCUS ON PERFORMANCE MEASURES

"I urge you to start thinking about appropriate rate-based measures that would be relevant to a purchaser of oncology services," said conference presenter David H. Tennenbaum, who provided insight into the direction the Blues are headed in this age of health care reform.

All purchasers of care will be using a greater number of rate-based measurements of performance, explained Tennenbaum, Director of Medical Management, Blue Cross and Blue Shield Association, Chicago, Ill. That means, for example, one focus will be on the rate of mammography screening based on 1,000 women members over age 40 or 50, On the acute and chronic disease front, the focus will be on readmission rates.

Tennenbaum noted that the neglected cancer registries will have much greater importance in the future, because increasing amounts of data will be requested. "Information systems must be created that will permit all cancer providers to submit data in a uniform way." Already the National Cancer Data Base has 1,200 institutions submitting like information that can be compared with regional and national norms.

Under the new model of health care reform, the payor and the provider will essentially be one and the same, said Tennenbaum. The immediate practical consequence will be quality measures that allow payors to look at an individual doctor or a provider to decide whether or not to allow that provider into its network.

One common set of measures already being used by many Fortune 500 companies is HEDIS, the Health plan Employers Data and Information Set. According to Tennenbaum, it is a report card that companies can use to judge health plans. The performance measures relate to quality, with the goal to measure a health care plan's performance in delivery of and access to services, as well as utilization and finance. A set of measures also relates to patient satisfaction and member retention.

Tennenbaum encouraged everyone to pay closer attention to ACCC standards, which represent optimal standards of care. He also described oncology as better positioned than other disciplines to conduct rate-based performance outcome measures. "By virtue of the care you provide and the registries you maintain, you are probably well ahead of the game."

Value, not price, will drive the system. Successful practices and cancer programs will be those that function like a business. Each will have to demonstrate economic incentives when it seeks to sign a contract with an insurance company, HMO, or health insurance purchasing cooperative. "You will have to demonstrate if their long-term costs will be less than their short-term costs. Do you have any alternative simulations to show relative to the competition?... What is your price? If you are not the cheapest price, I will ask, 'Is there any reason I should be paying more?' " said Berkowitz, who is Chairman of the Department of Marketing at the University of Massachusetts in Amherst.

Customer service is key to success. Berkowitz suggests "blueprinting" interactions with patients by identifying all steps in the process to deliver services and noting fail points, steps in the process that are likely to go wrong. Look closely at points of "critical incidents," including the reception desk and the waiting room. Evaluate waiting room amenities, timeliness of service, layout of facility, and, most importantly, patient satisfaction. Finally, Berkowitz notes, maintain communication with patients and do everything possible to ensure they will "buy the company's product on the next purchase."

Douglas W. Blayney, M.D., Wilshire Oncology Medical Group, Glendora, Calif., provided a to-do list of activities to begin immediately. High on his list were:

- Establish documentation strategies for Medicare and non-Medicare patients, including evaluation and management of services, chemotherapy treatment planning, and drug supply codes.
- Evaluate current fee schedule. Consider 1) increases in current E & M fees and chemotherapy services fees and 2) institution of compounding and mixing fees, fees for refilling and maintenance of infusion pumps, I.V. start fees, and a chemotherapy treatment planning fee.
- Evaluate each new therapy (drug, change in dose or schedule, substitute for existing therapy) based on its cost-saving potential.
- Evaluate primary care practitioners and your referral network, including diagnostic abilities, terminal care capacity, and services expected of the oncologist.

ACCC President Albert B. Einstein, Jr., M.D., (left) presents Nobel Laureate E. Donnall Thomas, M.D., with the Annual Award for Outstanding Achievement in Clinical Research. Dr. Thomas pioneered bone marrow transplantation in the 1950s. In 1956, he was first to show that marrow could be safely infused into a human patient. Later, he was the first to treat acute leukemia patients with marrow transplantation. As Director of the Fred Hutchinson Cancer Research Center's Division of Clinical Research for 15 years, Dr. Thomas headed the largest marrow transplant program in the world. He was awarded the Nobel Prize for Medicine in 1990.

WINNERS AND LOSERS

Whatever Congress decides about health care reform, "there will be a movement to managed care, and there probably will be cost price controls," said Joseph H. Bailes, M.D., Chairman of ASCO's Clinical Practice Committee.

According to Bailes, the final standard benefits package will contain language about clinical trials. "The key to the advancement in cancer care is coverage of patient care costs associated with clinical trials. If this is standard, state-of-the art care, it does not intuitively make sense to not cover this."

Bailes also believes the final bill will include—in some form—reimbursement for off-label drug uses and continued coverage of services incident to a physician visit. The likelihood of universal access to cancer specialists and to tertiary cancer care is much less certain.

"Winning cancer organizations will be those that have empowered cancer centers, meaning the medical director and the administrative director have the lion's share of influence over the cancer center's budget, operations, and planning," said Kent Giles, M.P.P.M., Executive Director, HCA West Paces Medical Center, Atlanta, Ga. He looks for leaner and more efficient organizational structures with fewer assistant administrators, assistant vice presidents, and assistant directors. Giles believes flattened organization structures will help move decision making closer to the bedside.

It will no longer be enough to review costs by DRG alone. According to Giles, we must begin to look at the entire cost of treating a cancer patient rather than merely reviewing the costs associated with a single surgery or treatment option. "Knowing what a DRG for mastectomy costs is not nearly as important as knowing what the entire incidence of breast cancer will cost over five years. Our challenge is to develop comprehensive treatment plans, i.e., clinical pathways that will allow us to improve patient outcomes (quality) while reducing costs. In other words, we must become better stewards of the

resources entrusted to us," he said.

To capture exclusive contracts and market share, physicians will become increasingly entrepreneurial and active in capitation, predicted Philip L. Beard, President, Pro-STAT Resource Group in Shawnee Mission, Kans. He questioned how many in the audience could pull out their average treatment plan and explain what is happening with their patients, their demographics, and how effective treatment has been. "When the Rand Corporation puts out an average treatment plan on cancer patients, you would be able to say, 'Here is where I stack up.' When you go for the capitation contract, can you show you are better?" asked Beard. Few in the audience raised their hands when Beard asked this question or when he asked for those who know what their top five payors actually allow for their top 10 procedures.

Beard foresees that nurse practitioners and physician assistants will have expanded direct billing options in Medicare and will also become direct contract practitioners in the private sector. His more gloomy predictions include a 25 percent earnings decline for many physicians and intense competition in hospital outpatient departments. According to Beard, hospital outpatient departments will see declining volumes due to competition from physician practices, multispecialty facilities, and single specialty centers of excellence.

POLITICS, AS USUAL

Politics, noted presenter John B. Benear, II, M.D., is not a familiar activity for physicians, and physicians have long not been particularly adept at maintaining their position in the political process.

As medicine moves into an arena where political concerns are paramount, the role of ACCC, ASCO, and the National Cancer Institute becomes increasingly important. Each organization has been active in maintaining advocacy positions for cancer patients and their health care providers. And each will be essential in monitoring progress in health care reform and in maintaining the position of adequate reimbursement for clinical practice.

Most conference presenters agreed with A. Collier Smyth, M.D., that there is a clear political mandate for health care reform and that managed care will become health care reform.

"Perhaps in the end," said Smyth, "the final evolution of managed care is to really focus on the outcomes, the big picture, the value of what is provided." And simply promote health.

PROFESSIONAL OPPORTUNITIES