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The final part in a six-part series that explores the future of multidisciplinary delivery of cancer care.

Challenges & Opportunities for Oncology Group Practice

by Lloyd K. Everson, M.D.

The decade of the 1990s is witnessing a broad restructuring of the health care delivery system in the United States. Alternative approaches to collaboration and comprehensive health services delivery are evolving into either physician dominated systems or hospital dominated systems. Regardless of what an individual oncology group faces in its regional markets, physicians are grouping together in multispecialty, primary care, and specialty dominated groups at an unprecedented rate.

These trends are developing without any major federal initiatives, programs, or interventions. It is the health care market forces that have compelled physicians to examine group and network strategies and, in turn, havè driven health care inflation to its lowest level in 15 years.

These rapid changes are happening in a background of:

- increasing demand for cancer services
- movement of cancer care from the inpatient to the outpatient environment
- lower length of stay for cancer patients in the hospital
- shifting of cancer care to physician extenders in oncology practices
- reimbursement incentives that favor private practice ambulatory care
- payer initiatives that are evolving into managed care strategies at the expense of fee-for-service medical practice
- increasing competition between oncologists and hospitals for cancer services.

Today oncology practices face an increasingly complex array of challenges. They are being asked not only to continue assuming the clinical risk for patients and their families, but are also being forced to assume the financial risk as well. Physicians have been taught to perform a history and physical, evaluate the laboratory and diagnostic radiology database, render an opinion, and assume the clinical responsibility of patient care during that patient's illness. Throughout their training and careers, physicians acquire the tools necessary to perform these duties and responsibilities. In essence, this is the "assumption of clinical risk."

Physicians, however, have not been taught the tools needed to assume the financial risk involved in taking care of patients. They have not, for example, acquired the skills needed to perform a comparable business "H & P" and analytically examine the business database of their practice. Yet, experienced professional business management is essential to deal effectively and creatively in the managed care markets that are evolving in health care today.

Oncologists, as all physicians, are faced with the challenge of planning proactively. The oncologist must assume the new responsibility of balancing patient advocate duties with assuming the financial risk in patient care.

Community cancer programs and oncology group practices have developed into superb, state-of-the-art programs that emphasize quality,

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comprehensive, integrated, and multidisciplinary care. If this vision of cancer care is to survive the 1990s, the oncologist will need to embrace and participate in a number of creative initiatives that aim at the partnering of professional business management and medicine.

PARTNERSHIP OPTIONS

In recognizing the need for business management, an important question for physicians today is, "Who will I choose as my business partner?" As practices examine potential partnerships with professional business management, four initiatives stand out as critical determinants of success:

- formation of oncology groups that aim to consolidate and integrate various oncology specialties and services
- integration of professional business management in oncology groups to implement effective cost-control measures, which in turn ensure quality of care delivery
- accession of capital to ensure market leadership
- creation and implementation of information systems to merge financial, practice management, and quality control databases into a coherent decision-making tool.

Successful partnerships depend on 1) the extent to which oncologists address and reconcile their personal and professional goals with these initiatives and 2) how effectively professional business management plans to implement these initiatives.

Aside from becoming an employee of an HMO, insurance company, hospital, or multispecialty group, two models of group integration and networking are available to oncologists: physician hospital organizations (PHOs) and management service organizations (MSOs). Variations on these models are evolving. In many instances, there are mergers of practices and buy-outs of practices by hospitals, groups, and MSOs.

Whether physicians choose to join a PHO or an MSO, concerns for equity, governance, financial security, and compensation will define their level of interest and degree of commitment.

Physician hospital organizations. PHOs evolved from a strategy to integrate hospital and physician goals into a joint venture that provides services to patients and coordinates managed care contracting. The primary advantage of a PHO is the formation of an alliance between the physicians and the hospital. Theoretically, PHOs would be expected to attract health plans because they can contract with both the physicians and the hospital through one entity. Through integration of services and professional business management, service efficiencies at reduced costs are possible. Another advantage of a PHO is that financing may be obtained through tax-exempt debt.

Today's environment of mergers and buy-outs is a compelling reason for an oncology practice to consider an appraisal.

PHOs, however, offer a few disadvantages to the physician. Because of differences in patient care philosophy and financial priorities, the relationship between physicians and the hospital may become strained. When there is disagreement, the hospital—usually the majority shareholder—may often prevail over the objections of the physician. In most PHOs, physician control is low.

Management Service Organizations. An MSO is a separate legal entity. In many cases MSOs have arisen as subsidiaries of hospitals. An MSO provides administrative and practice management services to its medical staff. In the past few years, variations on the MSO model, some of which are owned partially or entirely by physicians and outside investors, have evolved.

The principal advantage to physicians in an MSO is that, theoretically, it frees the physician from the hassles of running a complicated business. Many MSOs purchase practice assets; in many instances there is an immediate payback.

In contrast to a PHO, physician ownership and control is a principal advantage because physicians are shareholders and their input to the clinical and financial business plan is high. Financing occurs through a number of avenues, including investors and taxable and nontaxable bonds.

Disadvantages of MSOs include financial risk and problems with long-term integration. As physicians become involved in the ownership of the MSO entity, they incur the financial risks of initial capitalization costs and the possibility that costs will exceed revenue. Physicians will also lose some control of their office operations. In the case of hospital MSO subsidiaries, hospital personnel usually run the billing and collection functions. Because of their lack of experience of billing in an outpatient setting, practice collections may actually decrease.

To evaluate these partnership options effectively, the oncologist needs to understand a number of legal issues, including antitrust laws, federal and state antireferral laws, and Medicare fraud and abuse regulations.

PRACTICE VALUATION

Today's environment of mergers and buy-outs is a compelling reason for an oncology practice to consider an appraisal. Valuing a practice can also be important for estate tax planning, buy-in of new associates, buy-out of retiring physicians, financing, and determining adequacy of life insurance.

A number of important elements should be considered when valuing an oncology practice.

1. *Hard assets.* These assets include medical and office equipment, facility, and real estate. Of all the assets in a practice, these are generally the easiest to value, usually by a third party.

2. *Accounts receivable.* Generally, these revenues are recorded at gross and then adjusted to a realizable value (the revenue that might be collected in the future on an outstanding debt). Determining this realizable value may be difficult, since a determination is based solely on the historical collection experience.

3. *Goodwill.* Goodwill is the most difficult element to value because it is comprised of intangible factors such as reputation, location, referrals, patient base, and the ongoing earning capacity of the practice. A value for goodwill cannot be based on non-dollar-generating attributes.

4. *Liabilities.* Liabilities of a practice offset the value of its assets. Liabilities include outstanding payables, practice debt, and long-term lease commitments.

5. *Medical records.* Medical records are certainly of value and are often used as an element in practice valuation. However, American Medical Association policy specifies that the sale of medical records is an unethical practice because it implies incorrectly that patient loyalty can be bought and sold.

Although there are a number of accepted accounting methods for determining a practice's value, the ultimate valuation of a practice can be complex and depends on what the seller is willing to sell for and what the buyer is willing to pay in an arm's length transaction.

A potential buyer of a practice will find it difficult to place a high value on a practice with declining margins. Conversely, a practice that is managing its business for managed care may be in an enviable position to maximize its valuation. Many oncology practices today are at the peak of their earnings power. If they do not continue to be well managed, the managed care future of health care suggests that these practice margins will decline.

INVESTMENT OPPORTUNITIES

Because of the increasing demand from physician groups to pursue experienced and credible professional business management, group practice management services are increasing at an unprecedented rate. Physicians, hospitals, and investors are focusing increased attention on investor-owned businesses devoted to managing physician growth.

Oncology group management companies are acting as the catalyst to regional and national network formation. These networks are gaining acceptance and being embraced by many oncologists because they help partner oncologists with professional business management, capital, and effective information systems.

The group management investment sector is now a $24 billion industry. This sector is enjoying a 15 percent annual growth rate, influenced and driven predominately by the demand for physicians to form ever larger groups in the hope of ensuring a leadership position in local and regional markets.

Similar rapid growth is occurring in publicly traded managed care companies. As a market group, these companies comprise only about $456 million of the total management industry in the United States. However, the publicly traded investment area is experiencing a 30 percent annual growth rate. Again, the principal driving force behind the success and growth of these companies is the interest generated by physician groups seeking an enhanced competitive position in their evolving managed care markets.

By nature of their training and the demand of their patients, physicians have a fundamental interest in maintaining their independence.

Investor-owned management companies have a clear advantage over PHOs and hospital MSO subsidiary businesses. These companies are established by physicians and managed by professional business managers who are specifically recruited by physicians. Thus, investor-owned management companies retain the patient focus and advocate perspective of physicians. By nature of their training and the demand of their patients, physicians have a fundamental interest in maintaining their independence. In fact, it can be argued that independence of clinical decision making is essential for the physician to represent the patient's best interest. If offered the alternative, most physicians would rather remain independent of the hospital and the payer.

When an oncology group analyzes a potential relationship with a management company, they should examine whether the company has or is developing:

- a strategy to provide and enhance market and clinical leadership in the local community and region
- a plan to ensure physician perspective on assumption of clinical and financial risk
- a strategy to proactively compete in a managed care environment
- an information system that can integrate financial, practice management, and quality assessment practice
- strong financial capital backing
- a demonstrated ability to build group practice networks in more than one market.

The degree to which the organization has developed these strategies and elements will predict the ultimate success or failure of that partnership.

FINAL THOUGHTS

In any cancer program or medical practice, as in any business, there are at least three essential components that form the foundation for success: vision, organization, and financial strength. Vision is a shared understanding and commitment to the goals and objectives of the organization. Organization involves a clearly defined administrative authority and a disciplined team of physicians, nurses, administrators, and support personnel dedicated to implementing the business plan. Financial strength includes a strong financial basis (both capital and operational) for the organization or practice.

In the community cancer program or oncology practice, a fourth component is key to success: the leadership, participation, and commitment of oncologists.

Oncologists are facing a complex set of challenges. More and more, they are being asked to assume the financial—as well as the clinical—risk for their patients. Proactively partnering with professional management, accessing strong capital, and developing the information systems to support clinical and financial risk taking will spell success or failure for oncology groups in the 1990s. ■