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Emerging Threats to Multidisciplinary Cancer Care

Highlights of ACCC's 11th National Oncology Economics Conference

by Donald Jewler

To help members deal with the new world of capitated payment systems, integration, mergers, and institutional downsizing, the Association of Community Cancer Centers sponsored its 11th National Oncology Economics Conference, held September 28 to October 1. More than 300 attendees gathered in Newport Beach, Calif., to examine how hospitals and practices can survive and thrive in an environment that challenges the future of multidisciplinary cancer care.

"Clearly, a dramatic market consolidation unlike any in my career is taking place," said Robert T. Clarke, M.H.A., president and chief executive officer at Memorial Health System in Springfield, Ill. "From 1981 to 1992, for example, the number of hospital beds in Minneapolis declined from 9,188 to 5,348, a 42 percent decline. The number of hospitals declined from 24 to 19, and the overall occupancy rate declined from 75 percent to 71 percent." These figures, Clarke pointed out, are from the *Vision of the Future* by the Governance Committee of the Advisory Board Company.

Capitated systems, some say the only way to control costs, are spreading nationwide. According to Clarke, these systems are calculated to require 46 percent fewer hospital beds. "If our entire population were under capitation, the nation's hospital bed requirement would shrink from 927,000 to 498,000," he said.

As noted by many presenters during the conference, the spread of managed care is reponsible for the increasingly capitated environment, as well as linked to the unprecedented rate of hospital mergers, formation of extensive oncology group practices, and creation of integrated delivery systems.

Donald Jewler is Managing Editor of Oncology Issues.

HOW HOSPITALS SHOULD ADAPT

"The growth of integrated delivery systems and networks is symbiotic with managed care," said Clifford D. Stromberg, attorney and partner at Hogan & Hartson in Washington, D.C. He is chair of the American Bar Association's Working Group on Health Care Reform. "Managed care plans are looking for entities that can take risk," he said. "Integrated delivery systems can."

Some integration is necessary to effectively manage the continuity of care from preadmission testing, physician visits, and hospitalization to discharge and after-care, according to Stromberg.

He noted that during the last five years, more than 250 hospitals have merged. Small HMOs are being acquired. "There is a widespread perception that in each region, two or three integrated delivery systems will prevail—and that those institutions not affiliated with them will founder or fail."

How can community cancer centers respond to the increased penetration of managed care, the development of networks, and the diffusion of oncology services? According to Stromberg, the cancer care team must develop a strategic plan that involves some combination of specialization, downsizing, increased emphasis on ambulatory care, development of satellite centers, shared services, multihospital affiliations, and the creation of their own integrated regional system.

Sensible response strategies also include bonding with physicians, hospital/physician joint ventures, creation of centers of excellence, and bringing everyone together into a new corporate entity.

"Whatever you do, of course, the goal is to build value," said Stromberg. "Creating an infrastructure is really peachy, but it doesn't do anything for payers. The real question is, 'Can you make a credible argument that you are creating higher quality and better value?'"

In this new environment of increasing levels of managed care, the hospital-based program, if organized, will probably be the one to come out of the starting gate first and be able to compete first. That was the opinion of presenter James L. Wade III, M.D., ACCC trustee and director of medical oncology at Decatur Memorial Hospital Cancer Institute in Decatur, Ill.

However, according to Wade, the general hospital administrative structure may not be speedy enough to do contracting for a total oncology package. "You need a hospital contracting arm that will have expertise in oncology," he said. "The administrative division of hospital X cancer institute will need to contract with managed care entities to provide patients and capital.

"You also need an oncology business division with the cancer program to measure costs and to compare these costs to what your contractor is offering," he added.

According to Wade, hospital-based cancer programs will need to employ physicians willing to work within the program, a data system to keep track of costs and outcomes, and a clinical research program to improve quality and level of care, as well as provide an additional mechanism to generate income.

THE HOSPITAL AFFILIATION OPTION

There are many reasons why a physician might wish to affiliate with a larger organization.

"As providers begin to integrate, some physicians simply want to cash out," said Clarke. "Not only are integrated systems paying substantial cash for practices, but many are compensating physicians better

than they were experiencing as independent practitioners."

Physicians can gain influence and security when affiliating, Clarke continued. Primary care physicians often find their position of power is enhanced along with their income. Specialists, on the other hand, often find a sense of security even if their income is reduced.

According to Clarke, performance can often be improved through affiliation. In addition, affiliation often provides access to new capital for facility improvement, expansion, and equipment.

Clarke spoke of three basic models of affiliation. The first is the staff model, where an organization such as a hospital directly employs physicians and creates a subsidiary corporation that directly employs physicians and operates their practices. The second model is the foundation model, whereby a hospital or its subsidiary contracts for services with independent professional corporations. Finally, there is the equity model in which all physicians providing services to the organization are also equity owners of the organization.

Clarke suggested that the best choice is to affiliate with a vertically integrated system, which has been categorized into three different types: the insurance dominated structure, the physician dominated structure, and the hospital dominated structure.

"The successful health system must be vertically integrated, including not only a provider component that consists of primary care physicians, specialists, clinics, and comprehensive institutional services in all settings, but also the ability to accept risk or capitation," said Clarke.

Vertically integrated systems often extend over broad geographic areas, thus positioning themselves to serve multisite employers in many markets under a single contract. According to Clarke, these systems align hospital and physician incentives, resulting in a number of cost-reduction advantages that include fewer hospital days, high-cost interventions, and specialist visits.

When considering the internal issues relevant to the selection of a hospital affiliation, Clarke stressed the importance of examining financial stability. What is the hospital bond rating? Is the organization in good working condition? Hospitals today may have postponed capital improvements and failed to fund depreciation, he said.

Also look at external issues. What is the community reputation of the institution? Look at the hospital's relationships with other providers. Is it part of a network? Does it have a sound primary care physician base? Is that physician base well distributed geographically?

"It is absolutely essential to consider all the options. Those institutions you don't select may become your competition," said Clarke.

HOW TO THRIVE IN A SEPARATE ONCOLOGY PRACTICE

The New Hampshire Oncology/Hematology Professional Association is a six-physician oncology practice in Hooksett, N.H. Presenter and association partner A. Collier Smyth, M.D., is preparing to do capitated contracts, take some financial risk, and be appealing to payers.

A key step in the process, said Smyth, is to develop a customer orientation to the practice. Customers include his payers and referring physicians, as well as his patients.

"Once a month I sit down with each one of the major payers or clinics who are bearing the financial risk. I talk to them about where they want to go with oncology, how we can serve their needs, how we can change our practice to service them better, and we even discuss how we can get physicians to their facility.

"Whatever it is they want," said Smyth, "you have to not only verbally address their concerns, but also make changes in the way you do business."

Smyth and his partners are serious about patient satisfaction surveys. Nurses select articulate and outspoken patients and family members to be placed in a focus group that meets once or twice in a six-month period. "Their only job is to come up with a list of suggestions of how we can serve them better," said Smyth. "We respond to those needs. Then, when I sit down with the payers, I can show them the steps we are taking to better serve their patients' needs."

The physicians are developing the ability to capitate for oncology and to form a carve-out. One of the first steps is to link relevant clinical data with their own financial data. "We have six oncologists in our practice," said Smyth. "The only way we can change the way they deliver care and be more accountable for costs is to measure them. For adjuvant chemotherapy for breast cancer, for example, we look at cost figures for each doctor. Only by knowing each physician's costs relative to their peers (for a similar clinical situation) can each physician—and the group—make meaningful changes in the way they deliver care." Developing a practice analysis system is critical for understanding costs.

The physicians are also changing the financial incentives within the practice so that productivity alone is not determining how physicians are paid. "In a capitated world, you don't want to 'incentivize' people to do more, more, more," said Smyth.

He urged single specialty oncology practices to cultivate their relationships with the payers and provider networks—those people who are bearing financial risk.

"You have to court these risk bearers very actively, whether they be insurance companies, physicians, or hospitals," said Smyth. "You can't irritate anyone—a patient, a referring surgeon, a primary care physician, and most of all, an administrator of a large risk-bearing organization."

A very key concept, according to Smyth, is that we are moving away from an environment where historically physicians, hospitals, and even pharmaceutical companies have made their money on the basis of utilization of their services. "We are moving to an environment where the money to be made is made by accepting the financial risk for caring for patients and then controlling utilizations. The power of clinical decision making moves with the assumption of financial risk." This is a major change in the way physicians, hospitals, and pharmaceutical companies do business.

"If you remain a provider of services only, whether you are a physician, a hospital, or a pharmaceutical company providing drugs, you know in the future you will be negotiated down to your bare costs or below. There is no significant profit in that role," said Smyth. "The power and money in the future is with an organization that can accept financial risk and effectively and efficiently control utilization.

"Hospitals have taken a leading role in merging, aligning with each other, forming systems where they

A LOOK AT ACCC'S CLINICAL RESEARCH AWARDEES

Oncology's unique husband and wife team, Drs. James F. Holland and Jimmie C. Holland, were honored with ACCC's Clinical Research Award for their distinguished contributions.

James F. Holland, M.D., is long-time chair of the Cancer and Acute Leukemia Group B (CALGB) clinical trials cooperative group. He is currently Distinguished Professor of Neoplastic Diseases at Mount Sinai School of Medicine of the City University of New York.

"I applaud your continuing efforts to bring to the community an awareness that cancer as a group of diseases is not hopeless, that a great deal can be done, and that research finally is beginning to unravel the mysteries of the cancer cell," Holland told conference attendees. "Yet, bringing this awareness to the community is going to take a lot of high tech, a lot of money, and a national commitment."

High-tech oncology is crucial to progress in cancer treatment, Holland told conference attendees. He gave an eloquent update of exciting discoveries and developments, including colony stimulating factors, magnetic resonance imaging in soft tissue, immunologic upgrading of tumor antigens, and tumor suppression genes. "I believe that the development of drugs that imitate the products of tumor suppression genes is right around the corner," he said.

Jimmie C. Holland, M.D., is chief of Memorial Sloan-Kettering's Psychiatry Service in New York City. She has been at the forefront of efforts to delineate the prevalence and nature of the psychological and psychiatric implications of cancer for patients, their families, and health care professionals.

Psychosocial care, or "high touch," parallels developments in high tech, she said. For example, the identification of the gene for breast cancer creates its own set of anxieties and questions for women. 'Do I get the test? What does it mean?'

Holland raised concerns that in the 1995 National Cancer Institute budget only $2.2 million is designated for psychosocial supportive care. "That is less than 1 percent of what is allocated to long-term care of patients," she said. "I think that is faulty."

On the bright side, Holland noted that the Congressional Appropriation's Committee stated that there is increasing evidence that providing psychotherapeutic support for cancer patients is a low-cost, highly effective addition to other medical treatments. According to Holland, "the committee believes that NCI should require that cancer centers provide psychotherapy services at all stages to patients and their families."

can take financial risk and monitor utilization," said Smyth. "Now, physicians need to consider becoming part of an organization that can assume financial risk. That organization can be a commercial corporation —insurance-based, hospital driven, or physician run."

CAPITATING COSTS

Several presenters at the National Oncology Economics Conference examined capitation as a way for cancer care providers to reduce costs per case, while servicing an increasing number of patients and further enhancing quality.

"We can define capitation as an equal sum paid per person for guaranteed access to a defined set of health care services," said Kent Giles, M.P.P.M., executive director, HCA West Paces Cancer Center, Atlanta, Ga. (See "Capitating Cancer" in the May/June 1994 issue of *Oncology Issues*.)

Signing a capitation contract with an HMO or other party means agreeing to provide a defined set of health care services to some defined population at a fixed price per member per month—no matter what it costs to deliver a quality service. Capitated fees could include, for example, medical oncology services for $1.53 per member per month, cancer care for $18.53 per patient per month, or autologous bone marrow transplantation for $ .53 per member per month, according to Giles.

The long-term success of any approach to capitation, noted Giles, depends on a variety of factors, including information systems that provide evaluable cost and clinical data, procedure- and diagnostic-specific cost-accounting systems, and quality indicators that are outcome based.

"The more data you have the better your interactions with an HMO will be," said Cary A. Presant, M.D., F.A.C.P., president of the Medical Oncology Association of Southern California in Los Angeles.

According to Presant, outcomes data is of primary importance. "You must have some type of data to know how many total dollars you spent on a particular group of patients, how many encounters you had, how many consultants you used, how often primary care physicians were used, and what was the utilization of resources, such as lab and X-ray usage."

Other outcomes, noted Presant, deal with number of complications prevented, the patient's quality of life, and employment status—was the patient able to return to work?

"These outcomes must be accumulated," said Presant. "If you don't do it in your program, another program will come in to try to take the contract away. If they have the data, they will have an advantage."

According to presenter Thomas B. Johnson, C.M.C., M.B.A., of Deloitte & Touche in Chicago, Ill., "The first major issue that needs to be recognized when signing a capitation contract is that you transition from being just a provider of services to also being an insurance company."

That means managing the risk not only to secure good outcomes and high quality, but also to survive financially whole.

"The most critical factor is pricing the product," said Johnson. "Capitation rates are really a forecast, a prediction of the cost and utilization of services. If you compute rates incorrectly, you will not be able to manage your way out of a contract that has errors in it."

A contract should clearly define which oncology services are covered and which are excluded. "If complications such as pneumonia or pleurisy are in, you had better make sure you include the cost when developing the capitation rate," said Johnson. "Having a clear definition

of what is in and what is not will be the basis of estimating what it will cost you to provide the covered services and will also help to minimize contract disputes."

HEALTH REFORM AND STARK REALITIES

"There is no way a comprehensive health care reform bill will pass," said J. Thomas Ranken, manager of public affairs for Immunex Corporation in Seattle, Wash. He is a member of two investigation groups for the Washington State Health Services Commission.

A key reason is politics, said Ranken. "Eighty-five percent of the population likes the insurance and the doctors they have. They don't want any reduction in benefits, nor do they want to pay more. The 15 percent who don't have adequate coverage do not vote," said Ranken.

If meaningful health care reform is to occur in this country, it has to be done incrementally. "There is nothing wrong with incremental reform; it just takes a little longer," he said.

According to Randy L. Teach of the Medical Group Management Association in Washington, D.C., what doomed President Clinton's health care reform was that Americans really did not believe that multiple layers of government were capable of solving the nation's health care problems. Fear of doing the wrong thing may have led to gridlock in the Congress.

What will Congress do? Teach predicts no major heath care reform before 1997. Congress will be too busy with the budget, trade, campaign reform, and welfare reform. "However, Congress will go after fraud and abuse in a big way and act to allow states to enhance their efforts at reform. Legislators will also review antitrust issues and health plan regulation, such as whether an IPA must publish a fee schedule," said Teach.

The good news is that Medicare's default numbers become effective in January 1995. The bad news is that these increased reimbursements will be a one-year gift. According to Teach, there is no way to avoid reductions in Medicare payments. By the turn of the century Medicare and Medicaid will consume about 45 percent of the federal budget. Cuts are inevitable.

And those cuts will be substantial.

SPECIAL INTEREST GROUP (SIG) ROUND-UP

Nursing SIG. Judith A. Paice, Ph.D., R.N., discussed implications, implementation, and dissemination of the Agency for Health Care Policy and Research Management (AHCPR) *Cancer Pain Clinical Practice Guideline*. Paice is clinical nurse specialist and associate professor at Rush-Presbyterian-St. Luke's Medical Center in Chicago, Ill. She is a member of the AHCPR panel that developed and released the clinical practice guideline.

Pain management should be continuously monitored, according to Paice. That means assigning responsibility of pain management, documenting the assessment of pain and its relief, defining pain and relief levels to trigger a review, and surveying patient satisfaction.

Medical Director SIG. A session entitled "Changing the Nursing/Physician Paradigm in Oncology" was conducted by Sharon K. Steingass, M.S.N., nursing director in ambulatory care, at the Kenneth Norris Jr. Cancer Hospital in Los Angeles, Calif., and Deborah L. Bolton, M.N., R.N., O.C.N., of Huntington Memorial Hospital in Pasadena, Calif. They explored how fewer physician-to-patient resources will affect patient management by the oncology team. A physician's viewpoint was offered by Gordon R. Klatt, M.D., medical director, Cancer Program, Multicare Health Systems, Tacoma, Wash.

Administrator SIG. Three sessions were offered.

- Developing Your Own Critical Pathways/Care Maps. Presenters were Joy G. Stair, M.S., R.N., and Philip J. Stella, M.D., both of McAuley Cancer Care Center in Ann Arbor, Mich.
- Nuts and Bolts of Capitation: Pricing Your Oncology Products. Presenters were Robert T. Clarke, M.H.A., Memorial Health System, Springfield, Ill.; Kent Giles, M.P.P.M., of HCA West Paces Medical Center in Atlanta, Ga.; and Thomas B. Johnson, C.M.C., M.B.A., with Deloitte & Touche in Chicago, Ill. (See article for more details.)
- Continuous Quality Improvement: A Tool in Coordinating Cancer Care. This session was presented by E. Strode Weaver, F.A.C.H.E., director, Multicare Regional Cancer Center in Tacoma, Wash.

Radiation Oncology SIG. Looking at how radiation oncology will fare under managed care were Carl R. Bogardus, Jr., M.D., F.A.C.R., and Randall D. Kurtz, C.P.A. Bogardus is professor and vice-chairman of the Department of Radiological Sciences and director of Radiation Oncology at the University of Oklahoma Health Sciences Center. Kurtz works with the Physician Reliance Network, Inc., in Dallas, Texas.

CCOP Update. Panel participants included Rodger J. Winn, M.D., University of Texas M.D. Anderson Cancer Center, Houston, Texas, and Leslie G. Ford, M.D., of the National Cancer Institute (NCI). Ford is NCI's Branch Chief, Community Oncology and Rehabilitation.

"Clinical trials are the cornerstone of how we advance through science," said Ford. "We cannot be in a position where that cornerstone is questioned or becomes shaky."

SIGN UP NOW!

The Association of Community Cancer Centers currently recognizes five Special Interest Groups (SIGs): Administrator, CCOP, Medical Director, Nursing, and Radiation Oncology. The SIGs provide a forum for members to discuss ongoing ACCC activities, including the annual and national meetings, *Oncology Issues*, strategic planning, and other issues of importance. Increased SIG participation by the membership will continue to strengthen the Association's ability to be a national leader on issues of importance to all cancer care disciplines.

SIG membership forms were mailed to all ACCC members in September. Please, return your sign-up form today. If you have not received a SIG membership form, or if you want more information, please contact Katie Young, ACCC SIG Membership, 301-984-9496.

"Medicare may be ratcheted down to 50 percent of current charges," said Teach. "That should produce very serious access problems for some Medicare beneficiaries."

Teach is also concerned about other controversial cutbacks and "reforms" that may be looming, including mandatory assignment under Medicare, capping hospital medical staff payments, and the shift to pay primary care physicians more and specialists less.

Also disturbing are the provisions of OBRA '93, Stark II, which becomes effective January 1, 1995. Stark I applies only to Medicare, whereas Stark II prohibitions are extended to cover Medicaid as well. Although the final regulations have not yet been written, Stark II will have a major impact on physicians, who must divest outside investments in almost all ancillary and related services, according to Teach.

There is an in-office ancillary exemption. However, in order to qualify, physicians must meet the definition of a group practice.

"Now comes the confusing part," said Teach. "That definition has one element that has to do with physician compensation. The provision says that physicians cannot be paid productivity-wise based on their referrals within the group practice. That is, if you have a compensation plan and want to pass through to your physicians all the revenues they generate, you can only do that for those services that they produce with their own hands. If they see a patient or read an X-ray, you can pass that through.

"But here is the stinger: If a physician personally provides chemotherapy, it is pure productivity, and the group can directly compensate the physician for those services," Teach said. "However, if the nurse provides the service, even if under the physician's direct supervision, it is a referral under Stark. Anything you ask anyone else to do cannot go directly to you. That revenue goes to your group, and the group can divide it up among the physicians in some way based on patients seen or hours worked, for example.

"You have to break the link between the referral and direct compensation," Teach added. "If not and you are caught, it is $15,000 per paid claim, and you are out of business."

Although comprehensive reform failed to pass Congress, many members of Congress and the public have become more informed concerning the need for continued support of biomedical research, particularly as it relates to serious or life-threatening diseases like cancer, according to Joseph S. Bailes, M.D. He is a partner in Texas Oncology and clinical assistant professor at the University of Texas Health Science Center in Dallas, Texas.

Informal roundtables provided conference attendees with the opportunity to talk one-on-one with senior leaders in the oncology field and to network with their peers.

Bailes expressed concern that Medicare policy continues to say "no" to covering patient care costs and hospital/physician diagnostic tests in clinical trials. "Medicare has never promulgated a regulation about this. The experimental exclusion law is a major way to prevent paying for this."

Bailes, as chair of the Clinical Practice Committee of the American Society of Clinical Oncology, will attempt to draft a bill addressing the issue. "If we can get credible Congressional sponsors, hopefully we can find a place for it," he said. "I am not optimistic."

FINAL THOUGHTS AND NOTABLE QUOTABLES

No doubt, managed care will become the predominant method by which health care insurance coverage is administered by the year 2000.

"If you can't fight it, figure out some way to join it," said Carl R. Bogardus, Jr., M.D., F.A.C.R. He is professor and vice-chairman of the Department of Radiological Sciences and director of Radiation Oncology at the University of Oklahoma Health Sciences Center.

Key to survival is improving the efficiency of your operation. "Control the costs of your facility, labor, supplies, and the technology you use," he said. "You don't have to cut your fees to the bone, but you have to manage what you are doing."

Not only must programs and practices be increasingly cost conscious, they must also become more customer-oriented. "Your customer is no longer just the patient," said Douglas W. Blayney, M.D., F.A.C.P., president of the Wilshire Oncology Medical Group in Glendora, Calif. "He or she may be the medical director of a medical plan or IPA. You have to think of customer satisfaction."

Anyone entering into a managed care contract must be well informed. "Managed care contractors do not take ethics courses," said Randall D. Kurtz, C.P.A., Physician Reliance Network, Inc., in Dallas, Texas. "They want to win/win for their organizations. So, watch those contracts very carefully... and don't be afraid to lose a contract if it doesn't make good economic sense."

Perhaps A. Collier Smyth, M.D., summed up best the changes taking place when he noted that, "When elephants fight, it is the grass that suffers." Huge alliances and integrated health delivery systems are dramatically affecting hospitals and private practices. The health care team as well as patients may be the ones to suffer. "However," said Smyth, "it is our job to ensure that care continues to be delivered in a quality way."