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Oncology in a Managed Care Environment

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Individuals, employers, and payers for health care all agree that health care costs must be controlled. As a result, the health care system has begun the American free-enterprise, market-driven process of health care reform known as managed care. This aspect of health care reform is well underway and independent of any legislative action.

Statistics show that managed care penetration is greatest in the West where 37 percent of non-Medicare patients were in an HMO, 40 percent were in a PPO, 5 percent were in plans with a point-of-service option, and 18 percent remained in indemnity programs (based on 1992 figures). Contrast these figures with those of the East Coast where 23 percent of patients were in HMOs, 6 percent in PPOs, 16 percent in point-of-service plans, and 64 percent in indemnity plans. The Midwest and South were somewhere in between with 19 percent of patients in HMOs, 27 to 32 percent in PPOs, 4 to 16 percent in point-of-service plans, and 45 percent in indemnity plans.

Soon, oncologists throughout the U.S. will face the same pronounced changes that their colleagues to the west have already experienced. The lessons learned by those oncologists on the West Coast can serve as a guide to their colleagues in other regions of the country.

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ACCEPTING INCREASED RISK

As managed care programs have increased, different types of payment options have emerged. These include:

- discounted fee-for-service plans and closely related fixed-fee schedule plans
- case rates, common in radiation oncology, in which a fixed dollar amount is given for a particular diagnosis or type of service over a period of time
- capitation rates, in which a fixed number of dollars are provided per covered individual per month to care for a broad population—regardless of how many patients require services.

Discounted fee-for-service contracts, as well as fixed-fee schedule arrangements, have been favorable for oncologists' offices. In both arrangements, the oncologist is not at risk for any adverse utilization, since increased patient referral or more intense service brings about increased reimbursement.

However, in capitation contracts the oncologist is accepting considerable risk. In most capitated arrangements, professional services have been included in the capitation, but drugs have not. Chemotherapy has been contracted either at a discounted rate based on the average wholesale price or based on invoice plus some fixed percentage.

In a few contracts, capitation has included only professional services, with drugs supplied by the HMO and simply administered in the oncologist's office. This procedure decreases any incentive for excessive utilization of drugs and protects the relationship by avoiding risk for appropriate but expensive drug utilization. In some instances, however, capitation contracts have included both professional services and drugs. In these practices, practice parameters have been used to limit any excessive

utilization of drugs.

In some circumstances physicians have been unsuccessful in reducing use of expensive proprietary oncologic drugs, and the capitated rate for the drugs has not covered the cost of supplying the drugs. As a result, some of these oncologists have had to discontinue their participation in the HMO capitation contract.

Thus far, the field of medical oncology has not had experience with case rates for services (e.g., a fixed amount of dollars for providing adjuvant therapy for breast cancer patients on a per case basis). However, this type of payment has been very successful in radiation oncology, with a fixed rate for a single complete course of radiation therapy.

RESTRUCTURING THE ONCOLOGY MEDICAL PRACTICE

No doubt, the solo practitioner will not be able to survive in a heavily managed care environment. As a result, the individual physician and small groups of physicians are being confronted with a variety of restructuring options. Should the oncologist's office join a group, such as an independent physician association (IPA) or physicians' organization (PO)? Should oncologists work with networks that include not only an IPA, but also a management services organization (MSO) that manages the IPA's contracts? Should oncologists consider joining an integrated system, such as a physician-hospital organization (PHO), or actually consider selling their practice entirely to a hospital and proceeding as strict hospital employees?

The answers to these questions depend on the physicians' willingness to accept risk, their desire for a secure guaranteed income and/or vacation time, and their need to maximize income despite risk. Since these issues are dependent upon individual feelings, one of the most crucial evaluations that an oncologist can make is addressing his or her own personal values and needs. Business decisions must be consistent with those personal values.

Any restructuring involves certain risks. As individuals begin to join groups, IPAs, networks, or integrated systems, they may find themselves being recognized by the Internal Revenue Service as affiliated service groups with other oncology practices. The IRS has rules for affiliated service groups that can significantly impact retirement programs. Attorneys should be contacted to determine the affiliated service group effect of any particular reorganization.

New rules under the implementation of Stark II may prohibit oncologists from collecting profits from infusion centers or laboratory income based on numbers of patients "referred." These rules must be evaluated when looking at the types of reimbursement procedures that will be implemented during the restructuring.

SUCCESS IN CONTRACTING: COMMUNICATION AND DATA

Clear channels of communication with other providers are critical for success in contracting with health care payers. Strongly developed interpersonal interactions are crucial, particularly between the medical director of the managed care plan and the oncologist. The medical director usually determines which oncologists are selected to deliver care either exclusively or in a multiple provider type of arrangement.

The administrative officer of the HMO should interact with both the physician and the manager of the oncology practice. The primary care physicians (or medical group that is involved with the HMO and provides the gatekeeper function) should be in close communication with the oncologist. These interactions are time-consuming, but invaluable in developing and maintaining trust and in facilitating problem-solving.

As physicians face an increasingly complex array of options in determining how to go about contracting with health care payers, many kinds of data are useful in defining appropriate contract terms. The most important is the claims' experience, based upon the existing historical practice within the HMO for oncology and/or hematology patients. The sources of such data are:

1) the office manager in the practice, who should know how much business has been referred in the past from the HMO, the number of patients, and the total amount of dollars involved in the care,

2) the HMO, which can define the total dollar value of services in oncology that have been contracted previously, and

3) consultants, who should know the types of contracts already in existence in the community and the range of per member/ per month dollar contract rates in the area. Examining the costs of conducting care in the oncology office in two separate areas can be useful.

The costs of performing evaluation and management (professional services) activities should be separated from the costs of performing infusion center (technical) activities. Knowing these costs helps in deriving a total value or rate to place on services. It also enables a practice to track which centers are performing efficiently and which need cost-saving management decisions. Lastly, disease and regimen-based costs should be studied so that for any particular disease, and for any treatment, the success of delivering efficient care can be tracked.

In addition, data will have to be evaluated with regard to the patient mix at risk within the HMO. As risk changes (for example, a trend toward an older commercial population, a shift toward more Medicare patients, or the existence of more Medicaid entitlement patients), the appropriate value or rates of the contract must be increased because utilization will be higher. Examination of trends within the HMO over time is particularly useful, and availability of the HMO database is crucial to continuing successful contracting.

Once a contract is in place, utilization review is vital. The guidelines for utilization review originate from various sources, but utilization review guidelines must be used to establish a consistent level of both quality and cost containment. Templates for utilization review should include outlines of what drugs and what regimens should be used for various patients and frequency of visits and re-evaluations.

During times of open enrollment, adverse effects on the contract can occur. Patients who are sick and running out of dollars for indemnity-based insurance and facing an inability to pay the co-insurance portion often enroll in HMOs during open enrollment, resulting in an increase in utilization

of oncology services. Therefore, one should not base conclusions about the success of an HMO contract on the amount of utilization following an open enrollment period. Instead, track this process carefully.

OUTCOMES ANALYSIS

Evaluation of outcomes is critical to the successful implementation of capitation programs in oncology. An important outcome is utilization of resources, including total dollars used, number of patient visits, use of X-rays, laboratories, and radiation therapy, and number of hospital days used by patients on the treatment program. Each component must be carefully tracked.

Other outcomes that should be tracked include disease complications, disease survival (both crude and corrected for prognostic factors), quality of life evaluations, and performance status of patients. Outcomes should evaluate socioeconomic factors such as employment status (working or disabled) and functional status within the family. Oncologists should work with their center administrators, office managers, and nurses to be sure systems are in place to track as many outcomes as are appropriate.

Process outcomes must also be monitored. Are the patients meeting minimum standards for care for disease and stage? Who has written these standards? A panel of oncologists or a group such as the American Society of Clinical Oncology, the American Cancer Society, or others? Finally, the process should be evaluated by the patients themselves to track patient satisfaction.

ETHICAL ISSUES UNDER MANAGED CARE

Oncologists in the past have been trained to provide maximal intervention and symptoms support. Difficulties may occur in providing those interventions or support in settings of assumed risk under capitation. In many practices, patients have been shifted into hospice at relatively early times to avoid the continuing risk. In those circumstances, ethical issues regarding quality of care have surfaced. The pattern or timing of the shift to hospice care, for example, may have been earlier for the patient under capitated care compared with indemnity-type insurance plans.

Additional ethical issues to consider include:

- *The major manager of care.* Does the primary care physician continue as the major manager of patient care, or does an oncology specialist begin to assume the responsibility? In the latter circumstance, to avoid misunderstanding, a close relationship is needed among the medical director of the HMO, the primary care physicians in the HMO, and the specialist.
- *Site of care.* Oncologists who are capitated tend to shift as much care as possible back to the primary care physician to decrease the number of patient visits to the specialist's office. In addition, there is pressure to shift expensive drug therapy away from the office and into the hospital, where there is less financial risk for the oncologist. Moreover, where HMOs have external contracts with tertiary care centers, there may be an incentive to shift care from the community oncologist to the tertiary care center. This shift is based on economic considerations rather than actual needs of the patient and leads to difficulties in changing the community standards of care for an individual with a particular stage of disease.
- *Evaluation of care.* In the past, the oncologist has evaluated whether care has been satisfactory. In the future, however, since health plans are scrutinizing the costs of care, the satisfaction of the primary care physician, the plan manager, and the patient will become more important (relative to the oncologist) in determining whether satisfactory oncologic care has been delivered.
- *Competitiveness among oncologists.* Are community oncologists going to continue to collaborate in a collegial fashion, or do they become strict competitors who do not maintain professional and congenial attitudes toward colleagues? Oncologists must resolve these ethical problems prior to embarking on managed care contracts.

THE TREND AHEAD

HMO contracting across the country will undoubtedly increase. These relationships will include both commercial contracts and contracts for Medicare and Medicaid patients. Although payment methods will vary depending upon the size and experience of the HMO, all HMOs will tend toward capitated contracts in the near future.

Ethical dilemmas for oncologists will undoubtedly increase as the delivery of quality care competes with controlling costs. As a result, practice volume and income will polarize among oncologists. Those who are able to obtain contracts will undoubtedly see their practice volume increase, and if they are able to manage risk appropriately, will also see their incomes increase; those who are unsuccessful at obtaining contracts will likely see their practice volume dwindle and their incomes fall. Clinical research will be threatened in communities dominated by managed care HMOs.

The economic survival and quality of professional life of oncologists are threatened by these changes. Introspective evaluation of goals, needs, and values is of paramount importance for making the proper decisions to meet these challenges.

WHICH WAY CLINICAL RESEARCH?

In California managed care has had a deleterious effect on clinical research. Within the community, the use of treatment protocols has diminished as HMOs have adhered strictly to the contract criterion of exclusion of payment for investigational care. Partially as a result of this, the number of Community Clinical Oncology Programs (CCOPS) in California has decreased from seven in 1983 to two in 1994. Clearly, one critical issue in the emergence of cost-effective technology is the question of who will be conducting this research. HMOs that succeed in the future will probably have a way of including clinical investigation protocols for willing patients and evaluating the pharmacoeconomic effect of newer types of technologies and newer types of drugs on total managed care expenditures. Oncologists should work with the HMO medical directors to determine if certain clinical research protocols may have a benefit for the patient, HMO, and oncologists' practices.