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Donald Jewler & Cara Egan

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ReVisioning Oncology

by Donald Jewler & Cara Egan

More than 450 attendees—a record number—gathered for ACCC's 21st Annual National Meeting to learn the new ABC's of health care delivery: Alliances, Benefit Plans, Capitation, and Carve-outs. Speakers at the March 15-18 meeting held in Washington, D.C., included leading cancer program administrators as well as physician, insurer, and managed care leaders involved in rethinking traditional strategies and systems for the delivery of multidisciplinary cancer care.

The message was clear: Cancer care is in transition. Traditional fee for service is giving way to capitated payment systems; for-profit HMOs are experiencing tremendous growth. CIGNA HealthCare's 1994 enrollment, for example, was 3.2 million (up 42 percent from 1992) and Aetna Health Plans' enrollment was 2.9 million (up a whopping 92 percent from 1992), according to presenter John B. Benear II, M.D., a medical oncologist with Cancer Care Associates, Tulsa, Okla.

"We are caught between the old and the new," said Benear. "The old world is institution centered with high hospital occupancy, static organization, self-sufficiency, and referrals from patients and physicians. The new world is community centered with low hospital occupancy, fluid organization, strategic alliances, outcome measurements, and referrals dictated by contract."

As noted by many speakers, survival in this rapidly changing health care environment requires new skills and more cost-effective and value-oriented approaches to providing high-quality cancer care.

Donald Jewler is ACCC director of publications. Cara Egan is editorial assistant.

CAPITATION AND CARVE-OUTS

In the new health care world, medical groups and insurance companies are increasingly approaching an oncology group with a carve-out or capitation contract.

Why are they contracting with oncologists? "Very simple," said oncologist Myron H. Goldsmith, M.D. "They are finding they need, for example, one and a half oncologists. How do you get that? A group or a network gives the provider enough manpower to offer 24-hour coverage, for the same or less money on a capitated basis... and they don't have to offer physicians a benefit package."

Twelve years ago, Myron H. Goldsmith, M.D., signed a capitated managed care contract to deliver professional services for adult oncology/hematology. Renewed for each of the last 12 years, his agreement is one of the longest standing capitation contracts in the United States.

"With capitation, I saved a lot of time by not having to go through the authorization procedures for every visit and treatment," said Goldsmith, who works with the City of Hope Oncology Network in Duarte, Calif. "It has been a positive experience."

Will physicians lose income under capitation? Not necessarily, according to Goldsmith. "There is a presumed loss of income. However, you will lose income if you are not in managed care. With capitation you have less or no overhead and a steady income," said Goldsmith. "So, look at managed care as an opportunity, not as the devil."

Offering the insurers' point of view was David R. Ewing, M.D., M.B.A., medical director of Blue Cross/Blue Shield of the National Capital Area, Washington, D.C. "Capitation will increase market share, increase revenue, reduce cost, and, I believe, increase patient satisfaction."

Not all oncology professionals may share Ewing's rosy view. After all, capitation will result in reduction in absolute hospital beds and shorter hospital stays by shifting patients away from the hospital to a more "appropriate," less costly environment. Capitation will also cause inpatient chemotherapy to all but disappear, according to Ewing.

Will capitation result in underutilization of services? "No. I can tell you from my experience of over ten years I have heard of very few physicians cutting services," said Ewing.

Also espousing the benefits of capitation was Oklahoma oncologist John B. Benear II, M.D. "Capitation streamlines patient care, aligns provider incentives to reward innovation, and puts a premium on clinical and financial data," said Benear. There's the rub, however. Although physicians must attend to costs, most have no business expertise, according to Benear, and must obtain help with the details of complex contracting issues.

The demand for lower costs for complex care is increasing the number of carve-out benefit programs, according to Bettina Kurowski, D.P.A. Traditionally, HMOs and insurance companies define a carve-out as any portion of the benefit plan that is not part of the global service agreement. Payers look at carve-outs as a way to synthesize and enhance a health care program, while efficiently managing costs and services, according to Kurowski, who is senior vice president of managed care with Salick Health Care, Inc., in Los Angeles, Calif.

"In a carve-out, entire segments

of the health care plan's benefits are 'carved-out' and placed in separate programs. The primary care physician no longer retains control over that portion of a patient's treatment," noted Kurowski.

She provided insight into how carve-outs pay their physicians. "It is a mixed bag depending on the market," said Kurowski. "Medical oncologists and surgical oncologists are usually paid through a capitated pool. In some markets, they will be directly capitated, which increases their risk. In others, the pool is capitated and the physicians bill against the pool using Medicare, RBRVS, or workload units. They are paid the proportion of the pool that they generate each month. Physicians receive blinded utilization data. There is a lot of discussion and peer pressure over the utilization patterns, and the physician who is an overutilizer without good reason starts to behave differently."

In SalickNet, a wholly owned subsidiary of Salick Health Care, Inc., the radiation oncologist is paid a fixed case rate. The hospital-based physicians are paid a fixed fee—a negotiated fee based on RBRVS.

Capitated physicians in SalickNet are offered a "quality compensation model" of incentives, according to Kurowski. The model includes four areas:

1. quality of service, e.g., number of complaints and patient transfers
2. quality of care, e.g., compliance with practice guidelines and completeness of medical record
3. comprehensive service, e.g., does the physician offer after-hours chemotherapy or provide consult in the hospital within 24 hours when requested
4. managed care readiness, e.g., the level of participation in home care and patient management, as well as quality and completeness of the treatment plan.

"We use more than 30 different measures as a way to bonus physicians," said Kurowski.

According to Brian Campbell, regional director, Oncology Management Services, Caremark, Inc., of Schaumburg, Ill., requirements for carve-outs include:

- integrated information systems
- financial incentives for various disciplines to work together to plan treatment
- comprehensive service offerings
- protocols and guidelines that are tested and broadly validated
- the ability to report on both quality and economic outcomes
- a case management structure
- ability to control variable costs of cancer care.

"Your best position is in a network," advised Campbell. "So, organize with other experts where you can manage the risk, control market share, profit, and continue to grow in the new health care environment."

GUIDELINES AND CRITICAL PATHS

"We want to diminish variation, gauge and bring down the cost of care, and provide standards for quality," said Rodger W. Winn, M.D., chief, Community Oncology Program at M.D. Anderson Cancer Center in Houston, Tex. To that end, guidelines—a set of directives—can help promote conformity and create a clear understanding of which treatment strategies are appropriate for which patients at any stage of decision making.

Winn defined two kinds of guidelines: path and boundary. A path guideline is a management plan that enables providers to make sequential decisions about tests and therapies for a given clinical situation, in other words, a clinical algorithm. The typical path guideline will include work-up, primary treatment, adjuvant treatment, and surveillance. Boundary guidelines, such as ASCO's growth factor guidelines, take a modality or a procedure and define the limits of how that will be used. "Developing boundary guidelines is a much more labor intensive process," said Winn. "Make sure you know what all the alternatives are. For example, growth factors look very good until you consider that there is an alternative called 'decrease the dosage of chemotherapy.' "

Winn outlined the steps involved in "doing" a guideline. Since most guidelines are evidence based, a first step is to pull out all pertinent articles and rate the level of scientific evidence. The formalized development process must include validation, dissemination, and review of performance data and impact on health in general. Since guidelines must be outcome oriented, survival and quality of life data are important.

Honored with ACCC's National Achievement Award for Outstanding Contributions to Cancer Care was Nancy G. Brinker, patient advocate and founder of The Susan G. Komen Breast Cancer Foundation. Here, Elizabeth A. Hart, chairman of the board, The Susan G. Komen Breast Cancer Foundation, accepts the award from ACCC Immediate Past President Carl G. Kardinal, M.D. The Foundation is the leader in the field of breast cancer education, research, and legislative advocacy.

Once a guideline is completed, an economic analysis is necessary, especially with regard to choice of drugs and drug regimens. Yet, economic analysis is difficult. "We usually don't have the data to do this," said Winn.

For a guideline to be useful it must take into account all organ systems and presentations, according to Winn. The management of Stage IV breast cancer, for example, includes 22 scenarios. "There is no reason we cannot write 22 separate guidelines. Then, we get to the level of guideline where we make a great difference."

Where path and boundary guidelines tell you what to do, critical pathways tell you how to do it.

"Critical paths provide a diagram of a sequence of events that guide our performance. A critical path is based on time. We take a guideline, apply it to a critical path, and move the patient along the pathway," said Anne Flanagan, R.N., M.S., director of health care networks and ambulatory care services, the Joint Commission on Accreditation of Healthcare Organizations.

Among the many benefits of critical paths, according to Flanagan, are that they hold individuals accountable and allow us to see what it is we hoped would happen, what actually happened, and where the variance was. The variance becomes the foundation for a performance improvement model.

The case manager is key to the success of the critical path. "The case manager is keeper of the critical path—the captain of the ship—who is responsible for observing, checking, and assessing the critical path," said Flanagan.

The best way to fail in the development of critical pathways? Create an inflexible pathway. "Flexibility becomes the key ingredient to getting consensus among the team. We can't count on patients to keep their appointments or to take their medications. Flexible time frames and goals will allow for deviations."

HOSPITAL ALLIANCES

"Physician/customer relations, team work, cost-effective services—these concepts, redefined and re-energized, were the building blocks to what has been a successful reorganization," said W. Lee Hladki, vice president of network development, Michigan Capital Medical Center in Lansing. He reviewed the process of the consolidation of two distinct cancer programs following a merger of two community hospitals—the Breslin Cancer Center and the Pennsylvania campus outpatient oncology department. The consolidation created an opportunity to reposition the cancer programs as a center of excellence in an emerging, integrated health care system.

"The new and improved service is better positioned to meet the challenges in this rapidly changing and unpredictable health care environment," said Hladki.

Since the two organizations had different pricing and cost structures, staff spent "hundreds of hours sorting through pricing and putting together one structure," according to Hladki. Product line managers were eliminated, and product line teams were put in their place.

The team, which included the physicians, set the policy of the program. Management changed from a top-down approach to a full team partnership.

"If we don't do something different, our very successful freestanding radiation oncology program will not be around in five years because of what will develop around us, whether carve-outs or systems," said Paul E. Laudick, president and CEO, Centegra Health System in McHenry, Ill. Centegra represents a recent consolidation of two hospitals northwest of Chicago.

Describing the formation of the Fox River Area Oncology Consortium, Laudick said that more than 50 percent of cancer patients were found to be going outside the service area, which includes a 50-square mile area west of Chicago. The mission was to stem outmigration of oncology patients by eliminating the need for patients to travel outside the area for cancer services.

"We extended and expanded the level of oncology services. We have a general partnership of four hospitals, two with cancer centers." In addition, the Fox Valley Cancer Consortium is adding two radiation oncology centers to cover a broader geographic area.

HIGH TECH AND PATIENT ADVOCACY

The bottom line for BMT and other experimental treatments for cancer is doing what's best for the patient. That was the consensus of a panel that included representatives from the often-adversarial insurance and patient advocacy groups.

"We are all advocates when we have all the facts," said Elizabeth A. Hart, chairman of the board of the Susan G. Komen Breast Cancer Foundation. She called on physicians, nurses, insurance companies, and the community at large to become better advocates for breast cancer patients. Insurance companies should cover experimental drugs and treatments such as bone marrow transplant under approved protocol, according to Hart.

Fellow advocate Sharon Green, M.H.A., executive director of the Y-ME National Breast Cancer Organization, warned against overeagerness on the part of advocates as they demand access to treat-

The Honorable Patricia Schroeder (D-Colo.) was the featured speaker at the Congressional Breakfast and Forum, held at ACCC's recent Annual National Meeting in Washington, D.C. Rep. Schroeder told meeting attendees that although "we've come a long way since the days when the study of men dominated most research, women-specific studies still must be fought for in these times of limited funding." Rep. Schroeder has been deeply involved in women's health issues—in research, services, and prevention.

ments without regard for the scientific process. She admitted that without good research, a cure will never be found. But she also raised the following question: By offering an unproven therapy are we giving hope or encouraging unrealistic expectations? Advocates must realize that more expensive and more complicated treatments are not necessarily better for the patient.

To show the extent to which insurance companies are willing to initiate progressive policies on payment for cancer treatments such as BMT, David H. Tennenbaum, director, Specialty Networks, Blue Cross/Blue Shield Association, Chicago, Ill., discussed a new category of policy response that many of the Blues are adopting. In a limited way, the plans could offer financial support for BMT. This policy states that although a procedure is believed to be investigative or that net health outcomes have not been demonstrated, the plan is prepared to pay in some context. A cooperative agreement now exists among the Blues, the NCI, cooperative groups, and 17 plans. Under the agreement, the Blues will pay for patients who enter any of a set of three NCI-randomized clinical trials for BMT.

William McGivney, Ph.D., of Aetna Health Plans, Middletown, Conn., described how Aetna works with a panel of 200 leading oncologists who review cases, three oncologists per case. If one physician believes BMT is likely to be effective for a particular patient, the treatment is covered. Eighty-five percent of BMT cases the panel reviews are covered. McGivney emphasized that the most important question asked of the physicians is whether the proposed treatment is likely to be effective for the patient.

Categorizing BMT as "leading edge" research, William P. Peters, M.D., Ph.D., acknowledged the problems regarding reimbursement for BMT. Soon, however, he predicts BMT will move into the area of what he calls the "trailing edge," or an established part of medical practice. Insurance companies should reimburse for effective medical care, whether it takes place in the research setting or not, said Peters, who is director of the BMT and Laboratory Support Program at

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SPECIAL INTEREST GROUP (SIG) ROUND-UP

Nursing SIG. Nancy A. Nowak, M.A., and Teresa D. Smith, R.N., M.S.N., discussed restructuring the oncology unit to decrease costs while maintaining efficiency. Nowak is administrator of oncology services at Baptist Memorial Hospital in Memphis, Tenn. Smith is administrator, The Regional Cancer Center, Memorial Medical Center, Springfield, Ill.

Medical Director SIG. A session on "Capitation and Managed Care for Medical Directors" was presented by David R. Ewing, M.D., M.B.A., medical director of Blue Cross/Blue Shield of the National Capital Area, Washington, D.C. Details of his presentation are within this article.

Administrator SIG. Four sessions were offered.

- "Medicare, Managed Care, and Oncology Program Planning," presented by Nancy Bookbinder, M.P.H., president and founding director, Oncology Resource Consultants, Inc., McLean, Va.
- "Product/Service Line Management: The Basics," presented by Annette M. Conklin, R.N.C., O.C.N., executive director, Oncology Service Line, Memorial Health Alliance, Mount Holly, N.J.
- "Cancer Networks," presented by Peg O'Grady, R.N., M.S.N., O.C.N., clinical director, Fox Chase Cancer Network, Philadelphia, Penn.
- "Structuring Your Oncology Practice to Survive and Thrive Under Managed Competition," presented by Merrick Reese, M.D., of Physician Reliance Network, Inc., Dallas, Tex.

Radiation Oncology SIG. Looking at the economics of radiation oncology was Theodore J. Brickner, Jr., M.D., F.A.C.R., director, Department of Radiation Oncology, Natalie Warren Bryant Cancer Center, Saint Francis Hospital in Tulsa, Okla.

"Capitation places a maximum risk on the radiation oncology provider," said Brickner. "The problem with capitation is that in order to have some reasonable level of cost and income flow, the radiation oncology practice needs a very large base of patients. Otherwise statistical fluctuations can be economically intolerable. Nevertheless, it is quite easy to foresee the day when three quarters of our practices will be some type of managed care arrangement in which we are paid either by case rate management or capitation."

CCOP SIG. Panel participants included Leslie G. Ford, M.D., of the National Cancer Institute (NCI), and Otis W. Brawley, M.D., of NCI's Division of Cancer Prevention and Control. Ford noted that as of January 31, 1995, 11,112 patients have accrued to the Breast Cancer Prevention Trial. Close to 18,000 men have been enrolled in the Prostate Cancer Prevention Trial, with 12,519 randomized. Brawley reviewed important issues in prostate cancer.

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 Kathleen Young, ACCC SIG Membership, 301-984-9496.

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Duke University Medical Center in Durham, N.C.

Where fully effective care is not available, insurance companies should reimburse for patient care costs incurred during participation in studies for which there is adequate scientific justification, according to Peters. "The insurance companies should not pay for ineffective or less than optimally effective treatment whether it is considered standard therapy or not," he said.

What is certain about the future of BMT is that progress cannot be achieved without the active participation of all the groups that these speakers represent.

CANCER STATISTICS: WHERE WE STAND

"Are we winning or losing the war on cancer," asked presenter Paul Calabresi, M.D., M.A.C.P, who offered attendees his assessment of the problems and the promise of the national cancer program.

"In the 1950s, one in four patients survived. By the 1960s, one in three survived. Today, one in two patients with cancer will survive and be cured. We hope that by the year 2000 we will see two in three—maybe three out of four—patients survive. That indeed would be a wonderful goal to achieve," said Calabresi, who is Professor of Medicine and Chairman Emeritus in the Department of Medicine at Brown University/Rhode Island Hospital in Providence. He has served on several prominent committees and study sections of the National Cancer Institute and is former chairman of the National Cancer Advisory Board.

Although cancer mortality has decreased in people under 30 years of age (which represents the cures of leukemias, Hodgkins disease, etc.) and in the population under 45, an increase in cancer mortality is noted in groups aged 60 and younger and in those 65 and older, according to Calabresi.

"The fact that a downturn is not evident is troubling," he said. "We know from population projections that from 1995 to 2020 we can expect the population 65 and over to grow considerably. That means we can expect an increase in cancer in the elderly. Half of the people in America who get cancer will be over 65 years of age. That group is going to make geriatric oncology a serious consideration of which we all have to become more aware."

According to Calabresi, the national cancer program faces several major issues and obstacles, including an absence of national coordination, laws and government policies that undermine cancer prevention and control, a failure to support both translational and basic research, health care reform proposals that actually deny the resources necessary for research and quality cancer care, and the fact that many people—especially minority, elderly, and poor populations—receive inadequate or no cancer care.

"At the center of all this is the individual," concluded Calabresi. "It is the individual at risk and the individual with cancer who have to participate in cancer control and prevention." ■

PROFESSIONAL OPPORTUNITIES

EXECUTIVE DIRECTOR

Exciting opportunity to become Executive Director of a brand new free-standing cancer center. The center, which opened March 27, 1995, is located in an attractive midwestern community of 120,000. Support for the center is such that all outpatient care will now be provided under one roof to include medical and radiation oncologists. There are two new linear accelerators, a new CT scanner, plus the latest in computer systems. Interested persons should forward a resume to:

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Professional needed to manage core services of the Commission on Cancer related to hospital approvals programs, cancer education, and patient care standards. Extensive experience with proven success in one or several of the following: adult education, oncology data management, and cancer program administration or related Master's degree with 5 years' experience. Candidate should have cancer data and hospital level cancer program experience with increasing managerial responsibility. Excellent written and verbal communication and interpersonal skills essential. Must be effective in matrix/team environment. Excellent organization skills to manage multiple, competing priorities. Some travel. Excellent benefits.

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