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Part one of a three-part series

Oncology Networks: Genesis

by Brian Campbell

In the beginning there was darkness, fear, constant change, and small, independent groups of oncologists dotting the landscape. Then leaders emerged with a vision of a "network" designed to respond to changes in payer relationships, reimbursement methods, contract requirements, provider affiliations, and changes in the status quo. Suddenly, yesterday's fierce competitors became today's strategic partners.

This three-part series provides an overview of oncology network development. Part one focuses on trends in oncology networks and strategic planning. Part two will explore facility design and preparation for operations, including information systems, vendor accounts, and staffing. Part three will explore oncology networks in the context of managed care and marketing and will include a detailed account of contracting models, payment mechanisms, and negotiations.

Across the United States multiple groups of physicians and other providers are meeting to discuss forming networks. They are embracing the vision of a better way to offer quality, cost-conscious cancer care and acknowledging the need to join together to attract and maintain managed care contracts and patients.

Unfortunately, what started out to be a great concept—physicians, hospitals, and other providers consolidating into a strategic network—has all too often evolved into an exercise of futility. After numerous meetings in the discussion phase of network formation, for example, lawyers and accountants are invited to move the process along. Many models are reviewed, along with case studies, legal reviews, and a continual rehash of decisions already made in previous meetings.

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Even after one year, progress is often poor, and the network model is still on paper. The only change is that outgoing dollars have replaced billable hours.

In health care markets throughout the nation this scenario is frequent and unnecessary. Besides the inexperienced lawyers and accountants, the problem is exacerbated by the lack of experience and time that physicians and hospitals can offer to implement a single-specialty network strategy. Physicians are inundated with the demands of patient care and the requirements of their practices. Hospitals are consumed with medical staff issues for all specialties, daily operational needs, and the sea of shifting demands of payers and patients.

The solution is to lay out a sound plan that enhances your competitive position and focuses attention on factors that will affect network function and form. Such factors include the managed care and employer environment, physician resources and needs, and an assessment of market demand for services.

PLANNING AND ANALYSIS STAGE

Early in the network development process, it is essential for the lead group or core nucleus of groups to design and complete a strategic business plan. The plan is a working

document that identifies internal provider and external market characteristics. A variety of demographic and financial data must be assembled (Table 1). Careful data analysis will provide a realistic understanding of how to proceed in meeting the demands of the marketplace.

A strategic plan should point out opportunities in the market as well as detail the resources needed to capitalize on these opportunities. As each organization is critically reviewed, deficiencies will be identified. This information, combined with understanding each group's strengths, helps in selecting the right strategic partners for the network.

Typically, groups find two main areas of need during the planning and analysis stage: managed care readiness and information systems.

Managed care readiness is an in-depth process that begins with enhancing the internal organization so it can function properly under various plans and payment methods. The process ends with a service contract that meets both payer and network requirements.

A network's information system must accomplish multiple tasks, such as collecting and integrating clinical and financial data, supporting treatment planning, monitoring clinical trials, providing business office services, verifying eligibility, providing authorizations, and supporting operational functions in a managed care environment. The network's information system must offer "connectivity" to various external databases. Key to all of this are the system specifications and architecture as well as training and support.

SCOPE OF SERVICES

Network participants must identify types of services required by purchasers of health care in their markets. The strategic plan offers significant insight into this area. However, in the final determination of whether to include a service, you must analyze your financial benefit. In some instances, discount levels and cap rates make it unprofitable to offer all services. It is prudent in these situations to build a relationship with a payer by offering core services initially and adding other services over time.

In a risk-based contract, it is imperative to identify locations, providers, overhead/delivery costs, and capital needs required to provide services to a defined population. Knowing this information helps when projecting utilization of services and defining the revenue and expense relationships of treating a given population. As new population groups (i.e., Medicare-risk) are added to the network, understanding the revenue and expense relationships becomes a more complex exercise due to the variation of services, treatment requirements/intensity, and severity of illness factors.

In a capitated environment, numerous services are typically provided by a network through its participants or through ancillary provider contracts.

Office-Based Services
- medical, radiation, and surgical oncology
- malignant hematology
- chemo administration
- selected drugs and supplies
- office-based lab

Hospital-Based Services
- inpatient medical and surgical
- laboratory/pathology
- diagnostic imaging
- radiation therapy

Ancillary Provider-Based Services
- home care services
- pain management
- hospice
- counseling/training
- durable medical equipment

High-cost services, such as bone marrow transplantation and even lower cost prevention and screening services, are usually omitted from the scope of services. In certain instances, payers will give economic incentives to encourage providers to offer these services through a separate reimbursement arrangement or through longer term contracts.

The location of these services will vary by marketplace. Depending on factors such as managed care penetration, hospital vs. physician group dominance, and the growth of outpatient services, the majority of services will either be physician office-based, community cancer center-based, or hospital-based. Typically, it is the medical and/or radiation oncologists that initiate the single-specialty network effort in most markets, accelerating the shift of services to outpatient settings.

Other factors for consideration in determining the scope of services include staffing requirements, additional overhead costs, tertiary center affiliation, the potential duplication of services, competitor's service offering, and the costs of new technologies and therapies.

ORGANIZATIONAL STAGES

There are five essential stages in organizing a network: 1) Planning and Analysis, 2) Development, 3) Legal Design, 4) General Organization, and 5) Operations.

After completion of the Planning and Analysis Stage, the various network participants gather in a general meeting to sort out the "suspects" from the "prospects" in the Development Stage.

This is an important time in the formation of the network. Here leaders must determine if all oncology providers or just selected oncology providers will be invited to the network. The argument can go either way. However, experience suggests that it is better to have fewer, like-minded groups that are willing to practice under the rules of managed care than to struggle with a large, unwieldy group with overlapping service areas.

No matter the decision, there will be political battle lines drawn. The end result, however, will be a stronger and more manageable network. Be prepared.

During this stage it is also critical for the network leadership to select a consulting organization to facilitate discussions and to serve as the support staff throughout the remaining stages. A consulting organization can assess whether the network is "managed care" and address network needs and deficiencies.

A major part of the Development Stage includes selecting the network model (i.e., IPA, group/clinic without walls, freestanding medical group, PHO, foundation, as explained in Table 2). Then, network leadership should:
- define the network service area
- determine affiliation strategies
- identify ancillary providers
- develop network policies and procedures
- install information systems and
- model payments and internal distribution methods.

The next stage of network

formation, Legal Design, includes the development of network bylaws, establishment of articles of incorporation, creation of provider participation agreements, and design of the credentialing application and process.

A major component of the next stage, General Organization, is developing written documentation to support the internal network governance and planning. In this stage a variety of important policies and programs are implemented, including the goals and mission statement, utilization management program, quality assurance program, billing methodology, appeals process, grievance policy, medical director description and responsibilities, and ancillary provider contracts. Also during this stage, various committees are organized, including the finance committee, clinical committees, and the steering committee/board of directors. In addition, specific pricing strategies are developed (i.e., packaged discount, fee-for-service, percent of premium, case rates) during this stage. Finally, depending on the pricing strategies selected, factors such as reserves, stop/loss insurance, service offering, and tertiary relations are put in place.

The final stage, the Operational Stage, involves hiring the network management staff and/or a management services organization and implementing the various operational and support functions required for the network's day-to-day operations. In addition, marketing and development activities are channeled to the various customers of the network, including payers, employers, and physician groups.

LESSONS LEARNED

Although establishing a strategic partnership that delivers the highest quality medical care requires a sound plan, experience shows that no plan survives implementation.

Table 1. The Strategic Business Plan

Identifying internal provider and external market characteristics

Internal Provider

I. Service Area Definition
- Patient origin
- Disease-site trending
- Demographic profile
- Market share (city, zip)

II. Referral Characteristics
- By doctor or provider
- Revenue by doctor or provider
- Trending over time by doctor
- Profit contribution by doctor

III. Historical Utilization
- By service/department
- Comparative study
- Service life cycle

IV. Scope of Services
- Current vs. planned
- Contracted vs. provided
- Competitor analysis

V. Qualitative Assessment/ Surveys
- Payer, physician, and patient

VI. Financial Performance
- By service/therapy
- By physician
- In aggregate with variance
- Comparative data (i.e., MGMA, SACP)

VII. SWOT Analysis

VIII. Marketing
- Plans/activities
- Budgets
- Collateral

IX. Managed Care
- Contract review/terms
- Utilization trends by payer/plan
- Referrals, enrollment/lives
- Payment history/profitability
- Risk-based experience

X. Financial Performance
- Departmental/service level
- Balance sheet
- Cash flow and receivables
- Profit/loss analysis/trends
- Revenue sensitivity analysis

XI. Operational Performance
- Staffing/personnel issues
- Clinical services/support
- Reimbursement/business office
- Front office/reception
- Satellite/remote locations
- Information systems
- Physical plant issues

External Market

I. Demographic Characteristics
- Historical, estimated, and projected populations
- Employer profiles (top 20 government and nongovernment)
- Economic profile
- Health care spending (per capita state and federal)

II. Hospital Characteristics
- Utilization statistics (cancer)
- Service offerings
- Ownership (top 10)
- Severity adjusted data (comparative by hospital)

III. Outpatient Services Characteristics
- Facility profiles (location, services, physicians, utilization, affiliations, etc.)
- Service area/market share

IV. Incidence Rates
- By state
- By county
- By service area (registry data)

V. Payer Market
- HMO (covered lives, trends, average premiums, market penetration, ownership, model)
- PPO (as above, enrollment and operating data, etc.)
- Indemnity (as above)
- Medicare, Medicaid, Champus, and all others

VI. Physician Groups
- Demand and supply data
- Profile of top groups
- Managed care participation
- Locations and affiliations
- Scope of services

VII. Market Reconnaissance
- Payers: large employer contracts
- New industries in area
- Profile of ancillary services (lab, home care, hospice, radiation, etc.)
- Top multispecialty groups
- Top primary care groups

Table 2. Advantages and Disadvantages of Various Network Models

Model	Description	Advantage	Disadvantage
Independent Practice Association (IPA)	An organization that contracts with a managed care plan to deliver services for a single capitation rate. The IPA then contracts with individual providers to provide services on a capitated or discount fee-for-service basis.	Physicians can be IPA members yet remain autonomous and in control of their practices and non-IPA patients. Due to lower start-up costs, IPAs serve a lower risk model for managed care. Also, a preferred model for payers.	The selection and deselection process for participation can be difficult. Sometimes viewed as anticompetitive due to an IPA's ability to impact the delivery system.
Group/Clinic Without Walls (GWW or CWW)	A collection of medical group practices, professionally and economically integrated, while remaining geographically dispersed. Physicians maintain their practice entities, including assets, personnel, and systems.	Gives physicians autonomy and allows them to maintain their existing practices. Physicians retain substantial discretion in the choice of hospitals, specialists, and ancillary services.	Physician can contract directly with health plans, irrespective of the GWW's contracting efforts with the same plans. Little incentive to achieve cost reductions through shared or centralized services creating economies of scale.
Freestanding Medical Group	A group practice, single or multispecialty, with three or more physicians who deliver patient care, make joint use of equipment, personnel, and systems.	Multispecialty groups typically are market dominant and offer both primary and specialty physicians. Single specialty groups are typically smaller in number (there are exceptions) and are more cohesive operationally.	By accepting the medical group, payers have to accept cost and quality of all members; also tend to be specialty dominated. Disruption in patient care if contracts are terminated by either party, due to control of large numbers of covered lives.
Physician Hospital Organization (PHO)	A formal organization that legally and structurally bonds physicians to a hospital.	Joint contracting strength of hospital and physicians. Physicians remain in control of their non-PHO contracted patients.	Differing objectives toward managing care among parties (i.e., filling beds vs. using outpatient alternatives). Issues relating to control, utilization management, quality management, and provider selection are difficult to resolve.
Foundation Model	A tax-exempt, nonprofit corporation (foundation) that purchases practice assets, employs nonphysician staff, and operates the practice. The physicians join a separate, wholly-owned medical corporation, which enters into a professional services agreement with the foundation to provide services under the contract.	Physicians receive a one-time payment for "cashing out" of their practice. Economically structured to deliver cost-effective care. Transforms treatment locations from revenue centers to cost centers.	Physicians lose their autonomy and ability to re-establish their practices should they choose to leave the medical corporation (noncompetes, cost of setting up a new practice, etc.). Very costly and time-consuming to overcome many legal and regulatory hurdles (state and federal).

So, be flexible and conscientious in the planning process. A sound plan will be the foundation for good decisions as well as for alternatives.

Use an experienced consultant who has "been there, done that" in regard to network development and management. Experience has no substitute in this arena, and oncology experience within this same organization offers even greater advantages.

Another key point to understand is that the implementation process always takes longer than you think. Be generous in your time expectations. Remember, you already have a full-time job and then some. Again, an experienced consultant can help maximize your time and money.

Remember, it takes more money than you think. There are start-up costs, then working capital requirements and future capital needs. It can cost up to $1 million for an IPA, $2 million for medical groups, and $6 million for foundation models.[1] Most networks are unaware of the capital requirement over time, because they are funding the start-up costs from their operating dollars. Once established, and especially with risk-based contracts, a network is akin to an insurance company, and must have sufficient reserves for cash flow shortages.

Finally, keep it simple at the start. An IPA is the least threatening model; it gives the various groups a chance to establish a working relationship with some autonomy before establishing a more formal, restrictive structure. ■

Reference

[1]Mitka M. It takes money to merge. *American Medical News*, May 15, 1995, p.3.