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Part three
of a three-part series
on oncology networks

Managed Care, Marketing, & Physician Groups

by Brian Campbell and Chris Chandler

The one predictable element of any physician's future is that interaction with managed care organizations will increase significantly. Regardless of the extent of managed care penetration, physicians must be able to deal effectively with these organizations—whether HMOs, PPOs, PHOs, or even multispecialty groups—to preserve their share of the market.

Key to this, as outlined in the first article of this series ("Oncology Networks: Genesis" in the September/October 1995 *Oncology Issues*), is to know the external market. This assessment begins with demographics and patient origin, then expands to the activities of the payers and providers in the region. A thorough assessment will give rise to many strategic questions that physicians must be able to answer, such as:

- Which payers supply the network with patients? Under what payment arrangements? In what quantity of covered lives?
- What services are or need to be included in these arrangements?
- Are these payment arrangements profitable?
- What systems do the payers use? Is connectivity an issue?
- What are the strategies of these payers in the market?
- What effect, if any, will plan consolidation have on the network?
- Who are the main contacts for each plan?
- Which providers (affiliates or competitors) are on the plan panel? Are they at risk?
- What are the details of the capitated contract in terms of covered services and payment?

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WHAT PAYERS WANT FROM PHYSICIAN NETWORKS

Payers are looking for more creative and effective ways to manage their risk. Contracting with an oncology network allows a payer to "download" the risk of caring for this select patient population to the providers within the network. The more services offered by the network, the greater the dollars and risk the network providers are assuming from a payer. Responsible payers will work with the network to assure success and add value for plan participants and purchasers.

To remain competitive, the payer must deliver "premium value" to the purchaser of its plan(s) as well as deliver cost-effective and appropriate health care to patients and reimburse providers fairly. If these sometimes conflicting goals are not met, the payer will quickly find it difficult to compete. Therefore, a network must integrate the goals of a managed care plan into a well-functioning system *and* prove that it is providing value back to the payer.

The system requirements for a network to manage the maze of risks within a capitated arrangement depend largely on the number of lives under contract. The incidence rates for oncology applied against the population being served (age/sex adjusted) provide a comfortable range for the expected patient activity. The costs of systems vary from low-cost, basic reporting models to expensive, state-of-the-art systems with strong reporting capability and modules that add sophistication as the number of covered lives grows in volume. For an oncology network, basic systems that assist in managing capitation payments and claims adjudication (only) will range from $4,000-$7,000 (low-end) to $45,000-$65,000 (mid-range) to $125,000 and beyond (high-end). Fully integrated systems, which allow management of the clinical, financial, and reimbursement data requirements, can easily cost $500,000, plus annual maintenance fees.

Experience shows that for contracts with 20,000-50,000 covered lives, a network can get by within the low- to mid-range. Fifty thousand to 100,000 lives will require the mid-range system. Depending on how fast the network grows, systems in aggregate may exceed costs of $200,000.

Remember, the cost of a system and the initial overhead to support it require a significant working capital commitment. The ongoing cost of maintaining and supporting the system represents an equally significant portion of administrative expense, applied against the capitated payment.

THE OPTIMUM SERVICE OFFERING

Physician networks must include the implementation of a strong utilization management program. This program must:

- provide detailed and real-time information about lives under contract (i.e., benefits, copayments, service levels)

- interface with practice management systems in the network (regardless of platform) and facilitate capture of encounter data (clean/complete claim forms)
- distribute, based on fee-for-service or capitation, funds to network providers
- provide data for utilization review and management by physician/provider that is consistent with quality and appropriateness of care
- support prospective, concurrent, and retrospective review functions
- offer sufficient reporting capability for network staff, physicians, and contract administrators
- populate the outcomes database with clinical and financial information
- allow for upgrades and electronic interface, and have support available from manufacturers' representatives.

In a specialty setting, the optimum service offering should be a comprehensive package that provides all the essential health care services for that specialty or category of diseases. The optimum package will support the concept of "disease management" in that all of the care for cancer patients will be provided in this network. For example, an optimum package might include capitation for 1) medical oncology professional fees plus drugs plus office-based laboratory and ancillaries, 2) radiation oncology professional fees plus radiation oncology technical fees, and 3) other oncology professional fees (i.e., gyn, pediatrics). This service offering could be enhanced with the addition of hospital inpatient and outpatient services, home care and hospice, and surgical interventions. With the addition of the hospital and other surgical services, the comprehensive nature of the disease management under a risk formula will be realized.

The traditional model of capitation for only medical oncology services does not stimulate much interest from the payer community. This model simply impacts too little of the premium dollar. Thus, in today's market the minimum requirement seems to be an evolution to professional services plus drugs and ancillaries.

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The nature of today's fragmented delivery system makes analysis of the underlying utilization and cost equation for nonphysician services difficult. Networks are trying to develop risk-based models incorporating the majority of medical and radiation oncology services, while discount fee-for-service models remain the norm for the rest of the services. While payment rationales may differ, all services should still be coordinated and contracted for under the auspices of the oncology network.

Physicians should not underestimate the importance of patient satisfaction to managed care organizations, which also depend on the satisfaction of patients in winning and maintaining contracts. Each practice in the network should be able to provide survey instruments and results. Physicians should be able to explain the internal procedures implemented, from the time the patient enters the waiting room until he or she leaves the office, to ensure satisfaction. Many practices rely on the physician/patient interaction as the sole means to patient satisfaction. However, the interactions of the clinical staff *and* the administrative staff with the patient either make or break the satisfaction threshold. A frequent customer service training program and qualitative assessment are essential for any network of practices. Do not wait for the managed care organization to come to you. Manage your own perception by proactively sharing your results, actions, and special efforts to satisfy patients.

KEYS TO EFFECTIVE NETWORK DEVELOPMENT

Pay careful attention to the model used in network development. The broad categories of network development models are basically either *practice acquisition* or *contractual models*. The practice acquisition model is based on the purchase of practices in a given region. The physician then becomes an employee of the purchasing entity. A contractual model is based on the development of management contract relationships in which the physician retains his or her practice as an independent professional corporation and relates through a third-party organization in which the physician may have ownership, such as an IPA.

It is the author's opinion that the contractual models (nonacquisition) hold the most promise for developing new and effective delivery systems. The success or failure of the network rests largely on the commitment of the oncologists to effectively manage cancer cases, develop care standards, and modify their behavior as outcomes indicate. Incentives, such as participation in risk pools and cost savings, will play a major role in encouraging physicians to change behavior and methods. From an incentive standpoint, if an oncologist is paid substantially by a fixed salary, as in the practice acquisition model, it will be difficult to achieve rapid acceptance and changes required by payers.

The most viable model is one that allows physicians to retain

their independence and benefit from income streams generated from the practice and that provides oncologists with the business tools needed as they reengineer for managed care. This "independent physician-owned and managed" model should have several cornerstones.

- The oncologist is best suited to manage all aspects of the cancer case as a gatekeeper.
- The network must take the responsibility for all aspects of the care, from diagnosis on.
- Patients must receive clinically appropriate services.
- Physicians and providers must be paid fairly and equitably for their services.
- Physicians involved in managing the case should be compensated for assuming the risk and responsibility.
- The payer is assured delivery of cost-effective care, for which it can substantially budget.
- The relationship between value for dollars expended and patient satisfaction can be established.

Any system that incorporates the providers, the payers, and the business community into a real partnership will have an opportunity to succeed. This opportunity should not be taken lightly; each network should be creating new and effective delivery systems that have significant impact on the way oncology services are delivered. All avenues of reimbursement and incentive programs should be explored, including but not limited to capitation, discounted fee-for-service, package pricing, percentage of premium, and percentage of savings. Yet remember that the reason for providing care is the well-being of the patient.

MARKETING YOUR NETWORK

Most oncology practices have neither the personnel nor the resources to implement a full-time marketing program. An advantage of the network is the capability of pooled practice resources, and in some cases management company resources, to implement a sophisticated marketing program. Any marketing message should be concise and clear. In the case of an oncology network the message will most likely revolve around the following theme: The network is a clinically appropriate, cost-effective, physician-managed health care system. A clear statement such as this drives the mission statement of the network and must be incorporated into all communications directed toward physicians, payers, and the public. Consistent messages will increase the probability that the network will develop awareness in the marketplace.

Through successful planning a network can use the marketing infrastructure to communicate the interaction of existing service capabilities in practices with the enhanced service capabilities and new programs of the network. This is an important statement because the new network will raise questions within existing referral sources. Although the network has great promise for developing directed contracting capabilities and new referral sources, existing referral relationships must still be maintained and propagated. It is much easier to maintain business than to rebuild business that is lost.

Specific target audiences for the marketing message will vary by area and the particular stage of network or managed care development in that area. Direct consumer marketing is successful only to the extent that the consumer has a choice. Often this choice is extremely limited in a managed care environment. Generally, the greater the number of participating specialists and providers in a network (such as a PPO), the more they can be targeted. As a panel becomes more limited, as in an HMO, the traditional referral procedures give way to the "steerage" of the HMO. In this instance physician-to-physician referral relationships are still a factor. However, the network has a stronger opportunity to develop a direct HMO-exclusive provider relationship.

Marketing materials to providers and plans and other potential referral sources must be consistent in style and image. They should include the network's mission, providers, services, locations, affiliations with other providers and plans, specialized procedures and equipment, and specific descriptions of the quality-enhancing and cost-reducing strategies offered. The overall image and perception of the network should be communicated clearly and frequently.

Marketing the network is not simply a business or administrative requirement. Every physician and clinical provider associated with the network must participate. Encourage physician participation on managed care boards, advisory committees, tumor boards, local speaking engagements, health fairs, hospital committees, and other community-based activities. The commitment of the physician in promoting cost-effective, high-quality health care will have a strong impact on the success of the image presented by the network. A network marketing committee should be composed of physicians from each area of the network. They can collect and share a tremendous amount of "intelligence" in their daily routine.

Physicians and other providers have a unique opportunity in today's health care marketplace to create, implement, and operate highly effective delivery systems. Cooperative ventures with physician leadership and care management will positively reform the health care system.