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Emerging Oncology Compensation

by Bettina Kurowski, Ph.D.

The nation's move toward managed care to control health care costs is compelling many oncologists to join practice management companies, independent practice associations (IPAs), or medical groups. Some oncologists are forming their own provider networks. This situation has broad ramifications for the oncology provider industry as a whole and community cancer centers in particular. To compete and survive under the emerging paradigm, community cancer centers must find ways to work within the current system, which will allow them to provide quality care at a competitive rate.

Major medical centers and publicly traded oncology practice management companies (and their physicians) have a head start in developing networks of oncology providers and in working under managed care contracts. As HMOs and other payers typically contract with only one oncology network in an area, the logical question is, "Where does this leave community cancer centers, which have traditionally served a vital role in providing local, quality care?"

What is happening in Cleveland, Ohio, is a good example of what community cancer centers are facing in many areas across the country. Currently the Cleveland area is at about 15 percent penetration for managed care. Projections are that in just one year that figure will rise to 35 to 40 percent. To survive and capture a large segment of the market, several leading health care facilities, including the renowned Cleveland Clinic and Cleveland Community Hospital, have begun buying primary care physician practices and setting up satellite clinics. Physicians now associated with these organizations are bypassing community cancer centers and sending cancer patients to their own health care facilities.

Dale Cowan, M.D., is a Cleveland oncologist and past president of the Ohio and West Virginia Oncology Society. He has seen firsthand what can happen to community cancer programs when managed care enters the market. Cowan likens the situation to two 800-pound gorillas dominating the medical scene in Cleveland. To compete head-to-head with the Cleveland Clinic and University Hospital, he and a group of community-based medical and radiation oncologists have banded together to form Integrated Oncology Network. According to Cowan, other physicians at community cancer centers have or will soon need to look at similar provider networks.

DETERMINING THE OPTIMAL COMPENSATION STRATEGY

A central part of developing any network of health care providers is determining an optimal method for compensating or reimbursing physicians. Capitation may work for primary care physicians and some specialists, but will it work for oncology? Answering this question can mean the difference between success and failure for community cancer centers committed to working with HMOs and other managed care organizations.

However, unlike the early days of managed care when primary care physicians simply agreed to a capitated (per-member, per-month) reimbursement rate, physicians today have a plethora of remuneration options. In addition, some major employers and even the federal and state government are concerned that capitation promotes a reduction in services and level of care in order to meet budget projections. Therefore, many networks are looking at the feasibility of using a compensation system other than straight capitation.

Determining the optimal reimbursement method for community cancer centers involves examining a variety of current and emerging strategies and selecting the one or combination of choices that is best for that organization. These choices can include fee-for-service, case rates, or capitation.

Despite the growth of managed care, there is still an opportunity for *fee-for-service* oncology. This is particularly true in areas where managed care does not yet have a strong hold and for executives and retirees with "high-end" health care policies. Yet, even fee-for-service is modifying the approach. Today it is more accurately defined as discount fee-for-service or modified fee-for-service. It often is based on a percentage of Medicare allowable. Typically there is little if any management or quality assurance specifically associated with this particular strategy. Despite this fact, fee-for-service can be an appropriate and profitable component of a mix of compensation strategies. However, oncology groups that accept or offer only this arrangement in today's market could be limiting their long-term opportunities.

Because they work best for procedure-oriented services, *case rates* are another common method for compensating oncology physicians. This system is perhaps the most prevalent strategy for radiation

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oncology or bone marrow transplants. Case rates for radiation services are changing in heavily managed care environments from the traditional, complex, intermediate, and simple groupings to either global rates (all inclusive rates) or fees based on diagnosis and resource consumption. This change is primarily because some experienced purchasers are analyzing expenses and have determined that some providers have increased their use of certain techniques solely to increase revenue.

Case rates can range from a maximum in some areas of $8,000–$10,000 for high-intensity cases to as low as $3,000 for global exclusive rates in very competitive markets. Typically these rates include all professional and technical fees for one full course of treatment, with the professional fees accounting for between 30-40 percent of the case rate.

Case rates for autologous transplants using newer outpatient-oriented protocols have brought managed care prices down to the $60,000-$90,000 range—about one-half the cost of noncontracted procedures. These rates typically include all professional and technical fees for the transplant itself and include follow-up care for up to one year. Transportation and lodging can also be included in these prices for patients who travel long distances to the transplant center.

Capitation is still the dominant compensation strategy in a managed care setting. Today among all medical practices more than half of networks and IPAs compensate their physicians through capitation. Only 12 percent use fee-for-service with or without bonuses. Capitation rates are determined in several ways, including actuaries, experiential data, market forces, and rates that physicians are willing to accept. In competitive markets, prices can become extremely volatile as groups try to outbid one another for contracts. Ultimately such a tactic is a "lose-lose" situation for all parties. Plus, as the critics charge, unreasonably low cap fees can lead to lower levels of care. Mature managed care markets, however, have proven again and again that reasonable capitation arrangements, combined with stringent quality assurance measures, can actually lead to high-quality, more cost-efficient medical care.

According to Michael Alper, president of Meridian Health Care Consulting, a managed care consulting firm based in Los Angeles, IPAs and medical groups entering the managed care market should carefully research capitation rates for their industry and community to ensure they negotiate a fair and equitable price. Alper cautions that although a medical group may have access to experiential data from their own patient files, actuarial data is of equal or perhaps even greater importance. To develop this data, some oncology groups hire consultants or purchase the actuarial data themselves. Software programs that are designed to help determine cap rates are beginning to be introduced. For example, the American College of Radiology has created its own spreadsheet for estimating cap rates for radiation oncologists.

In areas where multispecialty IPAs and medical groups exist, capitated rates for medical visits, technical services, and prescription drugs are typically negotiated. In return, the group subcapitates individual oncologists within its network for a certain population of patients. Subcap rates vary considerably by specialty, experience, and practice area. However, once again experiential and actuarial data are key in developing and negotiating the actual rate. It is important for individual oncologists to stay on top of this data so that they may ensure they ask for and receive appropriate subcap rates.

When the cost of chemotherapy drugs to patients is a direct capitated expense for oncologists, there is greater potential for treatment decisions to be influenced by the cost of drugs. Although many managed care organizations capitate providers for chemotherapy drugs as well as medical services, some do not believe this approach is consistent with a successful managed care program.

Perhaps in no other specialty except oncology can capitation be spread out over so many areas. Medical oncologists and surgeons are traditionally capitated because they control the vast majority of services used in the system, including chemotherapy expenses and inpatient hospital stays. There are basically two schools of thought with regard to capitating cancer services. The first advises to accept as much risk as possible for services such as hematology, radiation, and chemotherapy infusion to receive a greater percentage of medical dollars. The second is a more cautious approach, which is touted by Gabriel Shapiro, M.D., president of Texas Association of Oncology Specialists, a network of twenty-five medical and radiation oncologists in the Dallas-Fort Worth metropolitan area. Shapiro believes that in areas new to capitation, there may not be enough utilization data to develop capitation rates for services such as nonmalignant hematology or for highly technical and expensive services, such as marrow transplantation. Instead, he and other industry experts recommend initially capitating oncology professional fees and possibly radiation technical fees, using discounted fee-for-service for other services. As utilization

data are collected and evaluated, chemotherapy drugs and other services could be included in a capitation formula. However, this stance should be balanced against what other providers are offering payers. If an integrated provider panel is willing to go at full risk for services, other providers might have to consider it as well.

BONUSES, PROFIT SHARING, AND WITHHOLDS

Any compensation strategy should also incorporate some form of system to reward physicians who meet specific quality assurance and utilization goals. Such systems can also help attract quality providers and ensure those who are not qualified or unwilling to work within a managed setting are weeded out. There are a variety of ways to structure such systems, from simple bonuses and withholds to complex risk pools to profit sharing.

The money for "bonus" arrangements may come from a variety of sources. With a withhold, a portion of the capitation fee not paid out to providers is reserved to reward physicians who meet certain requirements at the end of the year. Withholds are also valuable since they allow funds to be set aside for emergencies if needed. They are a particularly valid approach for emerging networks of oncology providers that must carefully manage expenses and may not have "profits" in the early years.

Risk pools are yet another way to provide additional compensation to providers. A risk pool is an amount of money or a budget set aside by the payer or by the medical group in a health plan based upon some high-cost budgeted items. Most common risk pools relate to inpatient or home care utilization. All claims are paid against these risk pools. At the end of the year, revenue remaining in the risk pool is shared between providers and/or the health plan.

A bonus pool is another option. Under the system developed by Salick Health Care, a withhold from a professional fee capitation pool, as well as a matching amount from the company, comprises the quality bonus pool. On a quarterly basis the quality bonus pool is distributed, based on a complicated point system measuring whether certain standards are met. Standards cover quality of care, quality of service, commitment to managed care, and comprehensiveness of care.

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Profit sharing, long a standard compensation benefit strategy in corporate America, may sometimes be used to provide additional monies to providers. Typically profit sharing is based on a formula. At the end of a year, it rewards and provides incentive to physicians with some portion of the network's excess revenue.

Whether using bonuses, withholds, or profit sharing in oncology, to avoid allegations of inappropriate care, it is important that additional payments be tied more to quality and outcome measures of care than to efficiency.

BUT THERE'S MORE

Simply selecting a compensation system may not be enough to ensure that quality and cost projections are met. Many oncologists now joining networks have practiced as solo practitioners or in small groups for many years. Although the vast majority are excellent physicians, they are unacquainted with the techniques managed care organizations stress to promote quality and cost control. To influence utilization and encourage behavior that best manages resource consumption, community cancer centers, IPAs, medical groups, and individual physicians must look at ways to change behavior as well.

HCFA, for example, has developed and funded a code for case management that allows monthly billing for all cognitive labor involving the supervision of patients at home. Salick Health Care uses this code, but allows physicians to bill for case management as often as they provide cognitive services. This process encourages physicians to participate more fully in the outpatient care process, potentially improving continuity of care and decreasing costs simultaneously.

Case management fills another important role as well. Successful cancer care demands by its very nature multidisciplinary interventional case management services. Such services range from coordinating support services to participating in telephone and electronic tumor boards. This type of case management support can go a long way toward assuring cost-effective and quality care.

Some oncology practice management companies solve the reimbursement dilemma by simply hiring oncologists to work for them. Physician employees can be paid as traditional employees, straight salary, or salary with bonuses tied to productivity. Although many younger physicians are comfortable with such arrangements, established oncologists, familiar to a degree of autonomy, may not be willing to work as employees. In addition, hiring physicians as employees may create a high level of financial stress on some companies.

The selection of compensation strategies for community cancer centers and their doctors entering the managed care arena involves a variety of factors. However, most oncologists believe the one item that cannot be neglected in the development of a compensation formula is patient advocacy. Oncologists should avoid the temptation to focus simply on a pricing structure and remember that optimal patient care, performed in the most cost-effective setting, should be the cardinal rule used to determine a strategy.

Using a "patient first policy" as the ultimate component of a reimbursement game plan will allow community cancer centers to develop a distinct marketing approach that will permit them to both survive and prosper in a managed care environment. ■