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How Will Medical Oncologists Maintain Their Incomes as Their Major Profit Centers Disappear? Disease Management Offers a Solution

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Disease Management

A Better Alternative to the Managed Care Process

How will medical oncologists maintain their incomes as their major profit centers disappear? Disease management offers a solution.

by Kent Giles, M.P.P.M.

Today health care providers face the challenges of lowering costs and improving outcomes while incurring greater administrative expenses and receiving lower reimbursement. While strategies such as DRGs, gatekeepers, utilization managers, discounted fees for service, capitated rates, and exclusive provider panels have helped bring the annual rate of health care inflation from a high of 14 percent in 1988 to a low of –.1 percent in 1995,[1] these efforts have done little to reduce the actual costs of providing care and have resulted in higher administrative costs from providers. Currently physician practices spend between 4 and 18 percent of their budgets providing payers with the information required to receive reimbursement. These payment requirements, precertifications, and other managed care controls have done little to improve patient outcomes. In fact, substantial anecdotal evidence exists to show that many managed care efforts have resulted in higher costs, lower quality, and significant hardship.

As an example, consider the case of an Atlanta woman whose insurance carrier permitted only a twenty-three-hour admission for a normal vaginal delivery. She endured a ten-hour labor with three and a half hours of "pushing," lost two units of blood, and was discharged from the hospital only twenty-one hours after delivery. Post discharge the mother required seven days' bed rest and recovered to only a hemoglobin count of eight after five days' post discharge. The baby suffered jaundice and required five days in home nursing care due to problems caused by early discharge. In this example the insurance company spent $1,200 after discharge for home care, pediatricians, and lab testing, instead of $350 for an extra hospital day and $55 for a home nursing follow-up visit two days' post-discharge. Fortunately, the child's father was proactive and took the infant to the pediatrician before the child's bilirubin count reached the point of causing permanent brain damage. In retrospect, where were the savings and how was quality of care improved by these managed care guidelines?

A second case in point is the 42-year-old prostate cancer patient who was enrolled in an HMO in South Florida and diagnosed with early stage prostate cancer. The patient was referred to a urologist by his primary care physician. The urologist, who is paid a per member/per month capitation rate, consulted with the patient and elected "watchful waiting" rather than surgery or radiation. Did managed care incentives force the provider to make a treatment decision based on economic factors, which resulted in the patient not being offered treatment? Did this HMO patient receive the "best available" treatment option or merely the lowest cost option? How does a patient or HMO determine

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the best treatment option?

These examples and many others force all Americans to ponder the question of health care cost and value. What is high-quality health care worth? In the United States we spend approximately 11 percent of our gross national product on health care, 10 percent on defense, 6 percent on infrastructure, and 8 percent on education.[2] Is access to the world's best health care system worth less than the amounts we spend on defense and highways? This is the key issue that we must consider as we begin to make changes in our health care system and will be the key issue that determines the direction of continued reform.

Until recently, Americans with a "good job" or Medicare benefits have been sheltered from health care inflation. However, as employers are becoming "lean and mean" to compete, and Congress is faced with greater pressure to balance the budget, health care spending has become a major target for cost reduction. In the private sector, companies are spending as much as 7 percent of their operating budgets on employee health care. In the public sector, the U.S. Department of Health and Human Services has issued data that show that the federal government is the fastest growing sector of health care, with Medicare and Medicaid spending representing 30.8 percent or $272.1 billion of the nation's total health care expenditures.[3] On a per enrollee basis, federal health care costs have increased from $3,806 per person/per year in 1992 to $4,162 in 1993, or 9.3 percent.[4] In the same period, total Medicaid spending increased from $68.3 billion to $76.1 billion, or 11.4 percent. As these costs continue to skyrocket, employed American taxpayers will insist on more cost-effective health plans for Medicaid and Medicare recipients.

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Americans are currently faced with the choice of either accepting a more restrictive and less costly managed care product that limits patient choice and access or spending more out of pocket for health plans that permit choice and broaden access. As Americans mark their enrollment forms and their ballots, they will be voting for the future direction of the U.S. health care system, i.e., to pay more for greater choice or to spend less for limited choice.

This article will explore disease management as a superior alternative to current managed care strategies. Disease management is a process that seeks to optimize the health status of a given patient population with a common diagnosis by more effectively integrating all programs of prevention, diagnosis, treatment, psychosocial support, and palliation. In contrast, managed care is a payer-driven process that seeks to reduce costs by limiting provider reimbursement, lowering the utilization of services, and controlling the practice of medicine through financial and other nonmedical means.

DISEASE MANAGEMENT OFFERS A BETTER WAY

An analysis of the nation's health care dollar based on 1994 estimates of expenditures shows that cancer care consumes $.15; heart disease, $.14; diabetes and its complications, $.12; and AIDS and infectious disease, $.06. The fact that $.47 of the U.S. health care dollar (or $423 billion) is spent on treating these four diseases is staggering.[5] Projections for the year 2000 suggest that figure will increase to $.61, with $.20 of the U.S. health care dollar spent on cancer care,[6] $.16 on diabetes and its complications; $.13 on heart disease, and $.12 on AIDS and infectious disease. Since between one-half and two-thirds of the nation's health care dollar is consumed in treating these four diseases, developing a system of care that more effectively manages each disease is the best way in which to improve quality of life and care while significantly lowering costs.

The key activities of a disease manager are to:

- determine and implement disease prevention strategies
- develop effective and efficient programs of early detection for treatable diseases
- develop the most effective clinical pathways (outcomes focused)
- eliminate unnecessary or nonbeneficial processes/waste
- integrate necessary components in a seamless or patient-friendly manner
- reinforce patient compliance
- define and measure outcomes (outcomes, quality, and costs)
- critically and objectively evaluate outcomes data (internal and external)
- continuously improve treatment processes and revise clinical pathways
- efficiently coordinate the care of the individual patient

A review of the task list for a disease manager illustrates the importance of having physicians in control. No other group of individuals is better qualified or more trusted than physicians to diagnosis and treat disease. From the legal

Table 1. Comparison of Disease Management with Managed Care

Issue	Disease Management	Managed Care
Focus on	best outcome	lowest cost
Costs controlled via	more efficient processes/less waste/early detection improved physician information	lower provider fees/fewer patient services/limited number of providers
Leadership via	physicians	payers/payer-loyal medical directors
Patient access controlled by	patient's physician	physician gatekeeper or managed care coordinator
Shifts patient management to specialist care at	diagnosis/prevention starts prior to disease	the discretion of the gatekeeper or coordinator
Provider networks and M.D. panels determined by	disease managers (M.D.'s) based upon treatment capabilities	bid process via payers usually awarded to lowest board-certified bidder
Patient follow-up by	appropriate specialist disease manager	primary care physician, specialist, or no follow-up
Saves dollars through	better outcomes, greater economics of scale, and reduced waste	lower provider payments and less patient utilization

and/or economic perspective, all substantial medical actions require a physician order; 75 percent of medical costs originate with an order. The power of the physician pen is the key to improving quality and value in the American health system. While this point seems obvious, many managed care scenarios seek to shift control from the physician to patient care coordinators or other less qualified individuals. Other managed care scenarios use economic behavioral modification to influence physician decisions. Most managed care strategies seek to limit physician autonomy and/or physician control of the treatment process and thus violate the patient/physician relationship.

CONTRASTING MANAGED CARE WITH DISEASE MANAGEMENT

While not all managed care activities negatively impact patient care (some excellent programs *do* exist), the focus of the managed care movement has been on provider cost controls via lower provider reimbursement, aggressive utilization management, reduction of subscriber benefits, primary care gatekeepers, and non-physician patient care coordinators. Most of these strategies require elaborate and complex information systems and complex interactions among physicians, payers, and patients. The end result is generally increased administrative costs that have no direct benefit to the patient. One Blue Cross plan in the Southeast increased administrative costs from $.05 per payment dollar in 1980 to $.12 in 1990 by implementing its managed care strategy. Table 1 provides a comparison of disease management and managed care.

Disease managers and managed care facilitators both seek to lower the costs of care; however, they go about their jobs in very different ways. The key differences are that disease management places medical decision making exclusively in the physician's domain. Managed care places patient control in the hands of primary care physicians or non-physician care coordinators—generally nurses or social workers who work from standardized guidelines selected by company-employed or incentivized physicians.

While everyone understands the role of the physician and the importance of the patient/physician relationship, few outside the insurance industry understand the patient care coordinator. Patient care coordinators can be grouped, although not precisely, into two broad categories: the shopper and the implementor. Under managed care, the shopper is a coordinator who handles special cases by seeking to lower the costs of patient care by contacting service providers, negotiating the lowest reimbursement, and arranging for the patient to be cared for by the lowest certified bidder. The shopper is used most often in patients who require long-term rehabilitation or high-cost treatments such as transplantation. The implementor is generally a patient care coordinator who is assigned patient cases and works with patients to ensure they receive treatment based upon their insurance company's guidelines and use providers with whom their insurance company has agreements, i.e., lower costs through shifting patients to lower cost providers and reducing high-cost utilization.

If quality, geographic access, and integration of services were consistent across all providers, these strategies could result in quality care. However, quality varies among providers, geographic access is not always considered by payers, and not all providers share critical medical information or work well together.

FOUR DISEASE MANAGEMENT EXAMPLES

In disease management, the patient with a specific disease is referred to the most appropriate physician at or prior to diagnosis. For the cancer patient, the central disease manager should be the medical oncologist. As a disease manager the medical oncologist's duties include ensuring accurate diagnosis, discussing treatment options with the patient and family, consulting other specialists as needed (referring physician, surgeons, radiologists, pathologists, radiation oncologists, therapists,

Table 2. Differences Among the Four Major Disease Groups

Process	Oncology	Cardiology	HIV/AIDS	Diabetes
Emergency care	<1%	85%+	<1%	20%[1]
Intensive supervision	1–5+ yrs.	1–3+ mos.	1–5 yrs.	lifetime
Follow-up	5 yrs-life	2 yrs-life	term of life	lifetime
Core group of specialists involved in treatment	12+	2	1	1
Patient geographic constraints	Need chemo, radiation, and follow-up close to home. Patient can travel long distances for surgeries.	Emergency care must be nearby. Patient can travel for surgeries. Follow-up needs to be close to home.	Need care close to home	Need care close to home for monitoring and follow-up. Need strong compliance program. Can travel for surgeries.

[1]Emergency care for diabetes includes complications such as diabetic crisis.

etc.), selecting the most appropriate clinical pathway for the patient's treatment plan, and providing medical oncology services and long-term follow-up. As a disease manager the medical oncologist would become not only a provider of therapy, but also a process manager and patient care advocate. In many practices the medical oncologist is currently functioning in this manner but lacks the authority or reimbursement to actually orchestrate the entire process.

Other examples of disease managers would include the infectious disease specialist for HIV/AIDS, the endocrinologist for diabetes, and the cardiologist for cardiology. Table 2 outlines the differences among the four major disease groups.

Of these four disease groups, cardiac represents the greatest degree of initial intensity, i.e., it usually begins with a heart attack and requires an intensive short-term care delivery model with long-term follow-up provided by a cardiologist or primary care physician. Diabetes precipitates some emergency care, diabetic crisis, surgeries due to disease complications, frequent monitoring of blood levels, and follow-up by a competent physician who can encourage patient compliance and assist in the aggressive management of patient insulin levels over the patient's lifetime. HIV and AIDS rarely require emergency care but demand significant ongoing physician management and psychosocial support. Cancer rarely results in the need for emergency care, but represents the greatest complexity in terms of diagnosis and staging of any disease and requires multiple interventions and lifetime follow-up by a competent specialist or team of specialists.

ESSENTIALS OF DISEASE MANAGEMENT

In developing a structure to effectively manage disease, the following are considered essential elements:

- well-trained and committed physicians as disease managers
- focus on best possible outcomes, early detection, and prevention
- documented clinical pathways that represent the best available care
- information systems capable of relating clinical and financial information
- physician network that uses common clinical pathways and shares results
- insurance company partner(s) or HMO licensure for network contracting
- demonstrated results
- geographic access that reasonably meets patient needs.

Since cancer is treated by multiple specialists and requires extensive treatment plans that use expensive technologies, successful oncology disease managers will be required to develop a core group of physicians who can evaluate patients in a multidisciplinary manner and treat patients on standardized clinical pathways. By treating patients on clinical pathways that are based upon the best available research and outcomes data, physicians will be able to deliver the best available care and gain the information to improve future treatment plans. Physicians will be protected from accusations of prescribing lower cost treatments over more expensive therapies to increase profits.

Physicians who accept at-risk contracts should be forewarned that a growing legal industry in this country targets for malpractice litigation physicians who receive capitated reimbursement or share in risk pools. Physicians lacking clinical pathways will have limited capability to compare outcomes and improve treatment plans and will lack vital support for their decision making in a court of law.

Disease management strategies also favor physicians who are members of a single network, limited liability corporation, or professional corporation. These structures place physicians in a better position to enforce adherence to clinical pathways, solicit contracts, and provide a forum for periodic tumor conferences, UM/QA meetings, and treatment planning sessions. Of the three structures, the ideal situation is to have all physicians as members of the same group and billing under one provider number. The group model provides numerous additional advantages in terms of sharing risks and costs for expanding facilities, internalizing ancillaries, enforcing clinical standards, and maximizing incomes.

Once a group of oncologists is formed and clinical pathways are in place, high-powered information systems that provide meaningful, measurable, relational, and compa-

rable data are essential. These data should include clinical data points such as months of life, blood cell counts, and diagnosis/stage, as well as information on resource utilization including drug costs, nursing and physician hours consumed, and overhead costs. Process improvement and cost reduction strategies cannot be effectively implemented without a relational database that combines medical and resource information. Without accurate and quantifiable data, physicians will be unable to make major improvements in the health care delivery process, and disease management efforts will fail.

Another key component of disease management is convenient geographic access. Patients receiving care require access to facilities in their communities. While patients can travel great distances to receive surgeries, transplants, or specialized care of a limited duration, patients receiving radiation therapy or chemotherapy need to receive care close to home, ideally with no more than a thirty-minute drive each way. Psychosocial needs of patients should also be addressed within the clinical pathway. Patient resources should be provided as part of the overall benefits package or made available to patients through other means.

Prevention and early detection are two key areas that should be addressed in the pathways. Resources should be allocated to prevention activities for the given population. New pathological/biological innovations, such as genetic testing to identify patients at high risk for certain diseases, continue to be developed and will eventually be used in prevention and/or early detection activities. From an economic and ethical standpoint, preventing disease is the best option, and capitated reimbursement rewards the concept. In diseases that are curable, early detection can greatly reduce human suffering, prevent death, and lower costs. Clinical pathways will need to identify appropriate screening guidelines and determine effectiveness and value.

Once the information system is in place and statistically valid data are available, a well-organized CQI program is mandatory. The program should be able to provide care givers and support personnel with a structure that allows them to effect positive changes in the clinical pathway and fully assess clinical and economic impacts of such changes. Combining a state-of-the-art information system with an aggressive CQI program can provide the group with the competitive advantages of providing higher quality care, lowering costs, and quantifying results. One model of combining these programs is contained in the clinical financial pathway model. (See "Using Clinical Financial Pathways to Capitate Cancer," Giles K., *Oncology Issues*, May/June 1995.) Other tools include an aggressive program of purchasing discounts, internal utilization management programs, and more efficient delivery models.

While no single system exists that is capable of performing all the functions necessary for disease and office management, there are a few companies that are completing beta testing and will have products available by fall 1996. Over the next decade, providers will receive greater scrutiny and be required to provide more tangible and evaluable information on their clinical outcomes. Providers who have the data and are able to manage disease will be in the best position to compete for contracts and profit.

As physician networks begin to demonstrate better outcomes, and private and government sector health care purchasers look for new ways to cut costs, direct contracting will become more attractive. Current laws require that a duly licensed organization be involved in any contract in which providers accept financial risk. This means that providers must either gain the appropriate licensure (HMO license, insurance license, etc.) and provide the initial capitalization, which can run as high as $3.5 million in fees, filings, and reserves. Otherwise a licensed insurance company or HMO must be involved in the transaction. These factors will likely produce new relationships between payers and providers and could result in a system in which the payers and providers combine forces to develop a better health care system. Disease management creates opportunity for such partnerships.

DISEASE MANAGEMENT'S IMPACT ON THE MEDICAL ONCOLOGIST

A major consideration for medical oncologists is maintaining professional incomes as reimbursement for chemotherapeutic drugs and in-office ancillaries such as laboratory tests declines. Almost one-half to two-thirds of a medical oncologist's income is derived from chemotherapy, drug, and lab codes. Thus, many medical oncologists are threatened by managed care strategies such as payer-provided drugs, requirements that all laboratory tests be provided by a designated lab, and various other assaults on these traditional profit centers. How will medical oncologists maintain their incomes as their major profit centers disappear?

Disease management offers a solution. Through disease management, the medical oncologist becomes the primary care physician—the principal physician who

coordinates care for the cancer patient. As the primary care physician and disease manager, the medical oncologist should be paid for his or her efforts in more efficiently managing patient outcomes, reducing unnecessary or nonbeneficial costs, and ultimately implementing measures that help reduce cancer incidence and increase early detection among his or her assigned populations. Under capitated contracts, the medical oncologist would have the opportunity to receive reasonable fees for such services as office and hospital visits, chemotherapy drug charges, basic lab tests, and chemotherapy administration at the prevailing rates and also receive the opportunity to share in a risk pool that would be created when capitated revenues exceed actual expenses.

Table 3 shows a provider network that has contracted to assume all financial risks for providing cancer patients with appropriate care, i.e., a cancer carve-out. In this scenario the oncology network has contracted with a payer to provide all appropriate oncologic care for a population of 200,000 covered lives. The contract defines which CPT codes (procedures) are included and uses ICD-9 codes to define the diagnoses that are considered cancer.

The network proforma show that the network is paid a monthly per member/per month fee of $20 or a total annual amount of $48 million for provision of all contractual services. Under various contracts with physicians, hospitals, outpatient facilities, skilled nursing facilities, rehabilitation centers, and other providers, the network incurred more than $43 million in expenses. The remaining $4.2 million falls into a risk pool. While there are a multitude of revenue-sharing options available for dividing risk pools, for the sake of illustration, this scenario assumes that the medical oncologists will receive one-third of the risk pool in recognition of their role in coordinating the care of the cancer patient, i.e., reducing inappropriate testing and inpatient days, improving patient care management, encouraging cancer prevention, and other activities. This translates into an additional $1.4 million in revenues to the medical oncologists.

Table 3. Annual Financial Summary of an Oncologic Disease Management Network

Contractual terms

PM/PM Rate = $20 Annual PM Rate = $240 Covered Lives = 200,000

Contract to: Provide appropriate care for all patients with a diagnosis of cancer (ICD-9) excluding bone marrow transplantation and non-oncologic diagnosis.

Network revenues		
Annual revenues	$48,000,000	
Total revenues		$48,000,000
Network expenses		
Network management expenses[1]	$ 5,760,000	
Surgical fees	$ 9,000,000	
Radiation therapy	$ 8,000,000	
Medical oncology	$ 9,000,000	
Hospital and services	$10,000,000	
Other providers	$ 2,000,000	
Total expenses		$43,760,000
Risk pool		**$ 4,240,000**

[1] Includes cost of disease management information system, UM/QA, legal, contracting, marketing, etc.

Disease management offers the medical oncologist the opportunity to become compensated primarily for managing disease rather than primarily administering chemotherapy. In terms of patient care philosophy, disease management creates new incentives to focus energy on improving patient management, enhancing efficiency, preventing cancer, improving patient support, and reducing unnecessary costs.

While managed care efforts have helped reduce health care inflation, and some managed care programs have been able to reduce costs while maintaining a high standard of care, most managed care programs have been payer rather than physician or patient driven. Strategies such as limiting patient access to certain providers in return for lower rates, aggressive strategies for reducing utilization, and countless "red tape" strategies that make accessing care difficult for the patient have characterized the managed care movement in this country and have weakened the patient-physician relationship. Disease management is a more patient-focused alternative that seeks to treat patients based on the best available clinical pathways; reduces costs through prevention, early detection, and more efficient use of resources; and eliminates nonessential personnel such as patient care coordinators, utilization review nurses, and other intermediaries.

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