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Strategic Issues & Challenges in Marketing Oncology Services

by Allan Fine, M.B.A.

Today oncology providers are inundated with multiple strategic options generally associated with some form of alliance or network participation. Although many cancer programs and oncologists are considering these options with the hope that they will bring some measure of stability, no single solution fits all oncology providers.

Factors that ultimately will characterize successful oncology networks depend on local and regional conditions. Strong leadership, active physician involvement, managed care contracting expertise, cost information, and clinical data are all essential prerequisites for developing a coherent strategy. Moreover, sufficient capital is required to develop a network offering a full continuum of cancer care services that will be attractive to the market. These challenges are arduous, but not insurmountable if providers understand their own internal capabilities and the external, competitive conditions that will continually affect their future.

SELECT A COMPATIBLE NETWORK PARTNER

The survival of oncology providers will depend in large measure on an adequate number of patients to achieve economies of scale, sufficient capital resources, and appropriate preparation to assume risk in rendering patient care. Oncology alliances are forming as a result of these challenges, and participants are asserting that this approach offers superior alternatives to solo initiatives.

To determine the value of participation in a network, oncology providers must first evaluate themselves as well as their potential partner(s). The evaluation should include a review of:

- compatibility with centralized mission, vision, and values
- quality of service
- full complement of clinical services
- compatibility of leadership and organizational culture
- existence of effective relationships
- organizational strength
- financial strength of potential partner(s)
- community perception of potential partner(s)
- extent to which potential partners' strategic initiatives are consistent with environmental trends.

Provider networks that have proven to be successful typically result in an increased access to managed care contracts, development of new programs and services to purchasers, and an increase in members' market share. Networks are successful when partners share common ideologies and are willing to rely on the network for valued resources.

Provider networks fail when members are unable to develop and implement localized programs that benefit the provider and when an ineffective managed care strategy prevents provider members from responding to various payers. In addition, networks may fail when physicians are not involved in marketplace penetration strategies and when information and other resources are not coordinated and shared among members. Network members must not place individual autonomy and self-interests ahead of network needs; instead, they must remain committed to the network's goals and objectives.

Providers considering either forming a network or becoming part of one must understand that doing so is a major commitment of time and resources and requires a shift in thinking, from a hospital to a system or network perspective. The process may ebb and flow with successes and failures. An open planning process, professional risk taking, and compromise at different stages are vital.

PREPARE YOURSELF FOR CAPITATION

Because cancer treatment is less predictable then other specialty services, payers have more difficulty in capitating physicians for the full spectrum of patient care. In general, for this reason, oncology services have been reimbursed on a fee-for-service basis. According to a 1995 study by Interstudy (The Interstudy Competitive Edge, Regional Market Analysis 5.2, 1995), 54 percent of specialty providers were reimbursed on a fee-for-service or discounted fee-for-service basis. Only 27 percent were capitated, while 17 percent received reimbursement based on a relative value scale. Many payers are questioning the preponderance of fee-based reimbursement and are intrigued by the potential of risk-based contracts in which oncology services are capitated.

As providers accept the reality of having to assume risk-based contracts, those offering oncology services will need to understand the dynamics and ramifications associated with negotiating capitation contracts. Capitation is a fixed payment per covered person, which is made regardless of whether the person becomes an active patient, without regard to the number and mix of services used by the patient. Capitation payments are tied to a given time period and are usually made on a per-member/per-month

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(PMPM) basis. Factors involved in determining capitation rates generally include population base, age, sex, utilization/use rates (expressed as rate per 1,000), and costs.

Providers must recognize that under capitation every service is a cost, and that to be profitable, every cost must be justified within a fixed-revenue budget. Examples of cost-effective measures can include telephone triage, physician extenders, patient education, self-care, and stricter referral criteria. Emphasis must be placed on preventive care.

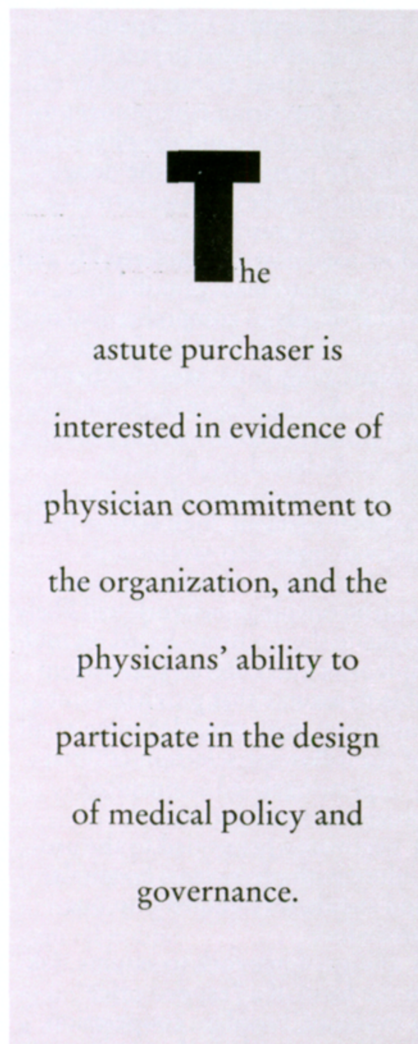
Oncology providers should ponder the following questions in preparing for capitation:

- What is the optimal cost/quality combination?
- What new practice/infrastructure capabilities are required?
- Which alliances will best position providers for the future?
- Who will be responsible in determining patient eligibility?
- What will be the procedure for authorizing forms?
- How will physician-encounter data be captured and reported?
- What internal policies and procedures will need to be established or revised to satisfy contract provisions?

Several actions are key to successful negotiation of capitation contracts. These include:

- performing a due diligence on the health plan's financial status
- understanding the contract by obtaining all administrative manuals, identifying the eligibility process, and differentiating between capitation services and covered services
- clarifying the length of the contract and its termination and renegotiation provisions
- identifying payment rates, coordination of benefits, late payment penalties, low enrollment guarantees, and utilization limits and guarantees.

Global pricing can serve as a



transition toward capitation. Global pricing or packaging is the process of creating and revealing the uniqueness of a product or service, proving its value for the purpose of increasing and retaining patient volume. Global pricing can provide the opportunity for hospitals and physicians to learn how to work together as partners in managing care.

Providers must have an understanding of the actual costs of offering specific sets of services appropriate for global pricing. Information systems are needed to track retrospective data. Specifically, providers need to be able to facilitate the determination of payment levels, assess outcomes and savings and adjust global bids for the future. An active dialogue between physicians and the hospital is essential, and the hospital must be receptive to sharing control and information with the physicians. An effective utilization management system is required, and there must be a sufficient impetus to share in the rewards as well as the risk.

The ultimate success for global pricing depends on proving that the hospital or network offers a unique product, one that is better, less costly, more convenient, and better packaged (with measurable results) than the competition.

MANAGE RISK

All too often providers lack an internal clinical performance tracking mechanism and subsequently fail to implement internal processes to effectively manage physician clinical performance. Many providers do not realize that plan incentive payments are often formulated according to the performance of the entire physician panel. Therefore, each individual physician's performance has a limited influence on whether incentive payments will be forthcoming.

Providers fail to manage risk if they do not keep track of each physician's performance. Measurable and enforceable internal processes must be developed to govern clinical performance, incorporating acceptable utilization guidelines that may include "best practice" protocols, outcomes measurement, and patient satisfaction elements. Providers need to understand the terms and measurement of group performance as defined by the contract, and then establish an internal tracking and feedback mechanism to monitor that performance in financial terms.

MEET POTENTIAL PURCHASER'S EXPECTATIONS

As competition for markets intensifies, providers of oncology services must be able to answer strategic questions:

- How does volume relate to revenue?
- Has there been a change in demand or has the capacity to meet demand changed?
- How have referral patterns changed?
- Who are the principal competitors and what are their strengths and weaknesses?
- How is managed care impacting oncology services?
- What are the opportunities in the marketplace for oncology services?
- What are the trends in the market that might be affecting the service?

Purchasers' expectations of provider networks and the services they offer will vary, and typically can be influenced by such factors as:

- managed care penetration
- level of competition among third-party payers
- degree of unionization
- level of employment
- composition of the work force
- overall size of the firm
- location where health coverage decisions are made
- degree of employer coalition activities in the region.

Purchasers expect an adequate supply of primary care physicians who play active roles within the organization. They are seeking information systems that enable the tracking of a cost-per-covered life and that support integration of services provided in different settings. Purchasers want agreement on standards associated with the use of high-cost and high-risk services as well as appropriate monitoring, reporting, and control mechanisms. Increasingly, they are searching for relationships with providers who are both receptive and capable of accepting risk-based payments. The astute purchaser is interested in evidence of physician commitment to the organization, and the physicians' ability to participate in the design of medical policy and governance. Ultimately, purchasers are seeking a low total cost-per-covered life and a structure to manage utilization, as well as access to comprehensive outpatient and inpatient services in convenient geographic areas for beneficiaries. Managed care organizations and insurers often evaluate provider networks based on physician responsiveness, ease of contracting, case management, high service level, and willingness to assume risk.

Purchasers seeking to contract with an oncology network will likely evaluate their options based on multiple selection criteria. It is reasonable to assume that purchasers, at a minimum, may consider some or all of the following selection criteria:

- expertise related to oncology procedures and services
- negotiated prices tied to the procedure with physicians, hospitals, and ancillaries bundled into one procedure
- ability of network to assume risk in the form of a "capped price"
- evidence, based on cooperation, for the potential of a long-term relationship.

IMPROVE PRODUCTIVITY AND EFFICIENCY

Oncology providers are confronting enormous challenges and should consider the following admonitions whether or not they are part of a network.

- Become more efficient in internal procedures, i.e., provide evidence that tangible steps are being taken to reduce overhead and expenses.
- Develop an infrastructure and management information system to track and monitor utilization and costs to ensure financial viability.
- Demonstrate a willingness to consider and implement capitated arrangements and other risk-sharing technologies.
- Document in an accurate, realistic, timely, and comprehensive manner outcomes of the procedures, i.e., demonstrating superior results compared to the competition.
- Demonstrate a willingness to share information with purchasers.
- Show evidence that the physicians in the organization or network are changing practice styles to reflect the "new order" imposed by managed care.
- Take the initiative in recommending pilot programs and studies that can be pursued in collaboration with purchasers to verify favorable outcomes and costs of treatment plans.
- Anticipate the evolving needs of purchasers and successfully respond to their needs.

Because of the continual technological and clinical innovations in cancer treatment, providers should include renegotiation provisions in any managed care agreement, protecting themselves from the inevitable increase of rising expenses associated with emerging treatment modalities.

Payers and purchasers are particularly interested in evaluating outcome measures, linking expenses to results. Considerable attention is given to clinical outcomes associated with cancer treatment, principally because diagnoses can be life-threatening. Patients increasingly are playing a role in care and treatment planning. The concept of demand management has emerged because of the intensity with which patients follow their course of treatment and monitor progress. Those centers that expect to be successful will need to improve their productivity if they hope to maintain their viability.

Hands-On Marketing Tips for Cancer Programs

by Patti Jamieson, M.S.S.W., M.B.A.

Not too long ago a cancer program's marketing program consisted mainly of local newspaper or radio advertisements and a few informational brochures. Little thought was given to defining the customer and market. Today, however, health care providers are increasingly shifting to outpatient services, and health care funds are shrinking. At the same time the health care consumer is more discriminating about the purchasing of health care services.

Since customers and payers are better informed, blanket statements about the value of a cancer program will no longer be accepted. Cancer programs no longer have the luxury of placing broad-marketed, glitzy ads to spark customer interest. Today, managed care requires more targeted approaches. If you place a newspaper ad and 80 percent of people who respond do not have an insurer with whom you contract, is this approach really cost effective?

In this changing health care environment, marketing a cancer program has become much more challenging. Indeed, ensuring that a cancer program's marketing dollars are carefully targeted to a defined market and maintaining and increasing market share have become critical for cancer program survival.

The first steps in any marketing strategy are to identify your competition and quantify how you compare. A cancer program should perform a complete SWOT analysis that details the Strengths and Weaknesses of your organization, the Opportunities available, and the Threats posed by the competition. This information will help in the development of a niche market, whether it be development of a comprehensive breast center, a women's health/cancer program, a pain management center, or a prostate center.

Dialogue with local physicians and/or physician groups is another critical component in marketing your cancer program. Establish collaborative discussions about joint ventures and business development issues, or ask physicians to assist in community outreach marketing programs. Include them in joint efforts of contracting with a local managed care company. Involve physicians in the development of critical guidelines/pathways. This information will lead to valuable outcome data (such as survival and complication data as well as patient satisfaction information) that can be used in marketing to payers and the general public.

To market your cancer program, follow these guidelines.

- Complete the comprehensive SWOT analysis.
- Identify the managed care penetration versus private indemnity in your geographic area.
- Develop a formal strategic marketing plan that includes measurable objectives.
- Identify key players who can implement the marketing plan and establish working committees to meet your objectives.
- Contact major insurers in your area to determine what they want and need from a cancer program.
- Visit major corporations in your area to develop and implement cancer corporate education and screenings.
- Keep hospital employees informed about the oncology services your cancer program provides, such as cancer screenings, support programs, and wellness programs.
- Establish a working relationship with local television and radio stations and newspapers.

Hospitals are again using focus groups to assess how the community, hospital and office staff, and physicians perceive their services. Physicians, administration, and operational staff should be included in the focus group process. Allow them to be involved in the development of questions, to observe the groups, and to help in the analysis and summary.

Focus groups should include participants who have used your services as well as those who have not been part of your hospital or cancer program. Although participants may give you information that you may not want to hear, to position yourself for the future, you must know their perceptions, expectations, and needs. Results from these focus groups will validate what you are doing right and give you information on areas of opportunity for growth and change.

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