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Patti A. Jamieson & Renee Matthews

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Managed Care and Its Future in Breast Center Management

by Patti A. Jamieson, M.S.S.W., M.B.A., and Renee Matthews, M.H.A.

Managed care is rapidly dominating the health care financing and delivery system in the United States. Approximately 60 million Americans are enrolled in managed health care organizations, and this number is expected to increase on a yearly basis. Recent media attention has focused on breast care and mammography screening guidelines, and the unwillingness of some managed care companies to cover the costs of screening services for women of a certain age. The results of this ongoing debate and other coverage issues will, more than ever, affect reimbursements at breast centers. In addition, the unstoppable march of managed care will force breast care centers to downsize and reorganize if they are to provide quality care to patients at a competitive cost.

To strategically position themselves for the future, breast centers must secure access to quality clinical and financial data, have accessible point of service for patients, provide access to clinical research, and continue to develop alliances with physicians. Presently, 65 percent of breast center referrals are physician driven, with only 8 percent being referred by insurers. With the growth of managed care, the percentage of insurer referrals will increase. Breast centers will have to balance treating larger volumes of patients while offering a full complement of services. Package pricing, comprehensive coverage, outcomes measurement, state-of-the art technology, and centralized billing will be vital for success.

Many breast care centers enter into managed care contracts without thoroughly understanding the costs involved in delivering that care. Much of this financial and patient information can be gained by investing in advanced information technology that promotes data access, sharing, and comparison system-wide throughout the entire breast care continuum. Quality care must also be cost-effective care.

Breast center directors are responsible for ensuring the financial viability of their centers. Systems need to be implemented to monitor existing managed care contracts and billing and reimbursements. Of course, how much a physician or breast center is reimbursed for a service will depend in part on the patient's insurance benefits. The reimbursement almost always varies from payer to payer, depending on the patient's benefits plan.

Reimbursement hassles can be minimized when cancer care providers educate patients about their role in the insurance process. Managed care organizations often require referrals for treatment, and patients are usually responsible for a small co-payment. Patients must be aware that selecting a provider out of plan may result in forfeited benefits. Women need to be educated on the unique services that are provided by accredited, quality oriented breast care facilities. Research indicates that women are willing to pay out-of-pocket for specialized breast care services.

Managed care will continue its penetration across the country and will undoubtedly increase. Managed care has had an impact on the breast center's ability to deliver care, and centers have already begun to restructure their organizations in response. Breast center administrators need continuing education regarding managed care issues to help them be flexible and adapt as the system becomes more complex and demanding of health care organizations.

THE BREAST CARE STUDY

A recent study by ELM Services, Inc., in collaboration with the National Consortium of Breast Centers. Inc., was developed to determine the impact of managed care on U.S. breast centers. Three hundred fifty breast centers received the two-page survey in March 1997. Forty-one centers (11.7 percent) responded (Table 1). Thirty-nine centers (94 percent of respondents) reported an increase in managed care penetration in their area; thirty-eight centers (92 percent) reported they are participating in managed care contracts.

A majority of respondents (68 percent) considers managed care a liability in terms of decreased patient access, lower reimbursements and revenue, compromised quality, and increased restrictions on patients. Cost was foremost on the minds of respondents: 76 percent believe cost is the determining factor in obtaining managed care contracts. Providers must lower costs and at the same time provide care that fits the enrolled population and improves the health status of their patients.

In general, breast center directors report that managed care policies affect the type and amount

Patti Jamieson, M.S.S.W., M.B.A., is oncology service line administrator at the University of Illinois, Chicago Medical Center in Chicago, Ill. Formerly, she was director of program development, ELM Services, Inc., in Rockville, Md. Renee Matthews, M.H.A., is manager of physician practice development for ELM Services, Inc.

of service provided to patients. Breast center directors believe that managed care accounts for lower fees, more capitation, difficult collection efforts, inferior quality patient care, and less reimbursement. More than half of respondents (54 percent) have experienced lower reimbursement.

However, among breast centers surveyed, fee-for-service currently remains the most common type of reimbursement, with 40 percent of respondents operating within this structure. Twenty-seven percent of responding programs bill under discounted fee-for-service. Equal numbers of respondents (13 percent) operate with capitation and per diem rates. Case rates and global pricing affect 4 percent and 3 percent, respectively. The vast majority (90 percent) reported receiving no reimbursement for clinical trials.

Managing costs with decreased reimbursement was identified by respondents as a critical issue. As breast centers are required to increase volume to offset the decrease in income, the threat of malpractice grows. Breast health care is already one of the leading target areas for malpractice. Guarding against the threat of malpractice will become more of a challenge as breast disease continues to be a high-volume service.

To compete and meet the new demands placed on them in a managed care environment, one-third of the breast centers responding to the survey reported that their programs have been re-engineered. They have downsized, reorganized administration, implemented flexible staffing during light and/or peak patient-load hours, and added mobile mammography. Even with these dramatic changes, 94 percent of respondents report their programs still employ non-revenue producing staff.

Breast health care is already one of the leading target areas for malpractice.

To meet the demands for better quality outcomes data, breast centers are seeking to improve patient satisfaction. Eighty-two percent of survey respondents report having an ongoing customer satisfaction survey process, usually by telephone, and most often twelve weeks post-op and again after one year. Patient wait time, access, use of equipment, and guideline compliance are monitored.

To increase patient volume, 33 percent of programs advertise in newspapers, 27 percent by direct mail, and 27 percent through sponsorships of education conferences. Just 5 percent advertise on TV and 2 percent on radio or billboards.

Other concerns common to many respondents include:

- the need for rapid diagnosis, more outpatient services, and better follow-up care
- increased malpractice and malpractice litigation
- the use of a primary care physician gatekeeper who will bypass the breast center
- the lack of patient choice and the decrease in time spent with patients
- the lack of adequate reimbursement for clinical trials.

Just 15 percent believe managed care is an asset to their program, keeping competition down, increasing awareness of their programs, and providing support.

Table 1. Program Characteristics of Responding Breast Centers*

Executive Staffing	
Full-time medical director	57 percent
Part-time medical director	43 percent
Full-time administrator	75 percent
Part-time administrator	25 percent
Medical Director Specialty	
Radiology	41 percent
Surgery	35 percent
Oncology	12 percent
Ob/gyn	6 percent
Pathology	6 percent
Referrals	
Physician	65 percent
Self	27 percent
Insurer	8 percent
*n=41	

Physician Arrangements	
Independent	71 percent
Employed	29 percent
Physician Reimbursement	
Reimbursed by third parties	67 percent
Reimbursed by breast center	33 percent
Multidisciplinary Conferences (34 respondents)	
Weekly	75 percent
Monthly	25 percent
Total Operating Budget (16 respondents)	
Lowest	$ 125,000
Average	596,473
Highest	3,000,000