Going Hospital Based: Nuts and Bolts Operational Issues

By Teri U. Guidi, MBA, FAAMA

Oncology Management Consulting Group, Pipersville, PA

Abstract

For the past few years, there has been a rising trend to shift outpatient infusion services from the private practice setting to the hospital outpatient setting. Numerous and complex

factors are driving this trend. More complex however are the myriad details required to operationalize a change in structure and ensure that all parties are clear and comfortable with the outcome.

Introduction

In recent years, there has been a marked increase in the transfer of outpatient infusion services from the private practice setting to a hospital-based setting. The factors that are driving this trend are numerous and complex.

Financial issues are, arguably, the greatest driver. For several years, payers have been exerting pressure on providers of infusion care, particularly on private practices. Payers, including Medicare, continue to seek means of decreasing their costs, and chemotherapy drugs rank high on their lists. In 2005, the Centers for Medicare and Medicaid Services (CMS) changed the methodology for reimbursement for drugs from a percentage of average wholesale price (AWP) to a percentage of average sales price (ASP). In that same year, a report issued by the Office of the Inspector General¹ estimated that the median price difference between ASP and AWP was 49%. And in 2006, MedPac issued a report noting that Medicare expenditures for Part B drugs declined 14% between 2004 and 2005.² Thus it is clear that the change from AWP to ASP as a reimbursement methodology caused large declines in practice revenue derived from the delivery of chemotherapy. In addition, Medicare and many other payers continue to adopt policies regarding the acceptable use for a variety of drugs, further limiting a practice's options and reimbursements.

Looking to the future, we expect to see more sweeping changes in the overall reimbursement methodology, slowly eliminating the current fee-for-service approach in favor of a variety of so-called "bundled" payments, case rates, shared savings arrangements, pay for quality, and so on. Many of these emerging models will force physicians of all disciplines and hospitals of all kinds to work more closely together in order to remain in the game. For example, physicians and hospitals will likely need to combine clinical and financial information systems in order to meet payers' requirements such as documentation of adherence to and improvement in quality and utilization measures.

Somewhat related to the financial pressures are issues associated with the administrative burden of running a viable infusion center. These include the added staff time to manage billing and collections for a wide variety of complex payer rules,

calling and filing forms for referrals and preauthorizations, managing the staffing and operations for the business, and so on. And as the landscape continues to evolve with new reimbursement models, moving away from fee-for-service to other approaches, many physicians are becoming disheartened as the complexity of running a sustainable practice comes to overshadow the complexity of caring for patients with cancer. Further, as the physician population ages along with the general population, many yearn for a return to the days when all that was required was to be a good doctor.

Thus, many physicians are interested in a change that will allow them to do what they trained to do with fewer headaches and hassles, and to be part of emerging models such as accountable care organizations and shared savings plans. One of the most common choices is to align in some manner with a hospital, moving the infusion business to the hospital's outpatient department. As those alignments are defined, it is important to bear in mind that there are myriad details to be worked out before finalizing such an arrangement.

Control Issues

Control is among the greatest concerns we see physicians struggle with. Privately practicing physicians are accustomed to being captains of their ships, and ceding control can be quite unnerving. For example, in a private practice, the physicians have total control over staffing, including salaries and benefits as well as hiring and firing decisions. When staff become employed by a hospital, those controls may evaporate because the hospital has policies and procedures that must be followed. Items to include in the negotiation include an understanding of any policies regarding the number of full-time equivalent staff, staff certification and credentialing requirements, pay scale including bonus opportunities, staff duties (ie, will staff be expected to take on responsibilities that are unfamiliar or will they be restricted from performing tasks that they previously handled?), and how the transferred staff can retain established seniority.

Further, control over the simplest of things such as scheduling (how many patients per day, how much time per visit, etc) may fall to administrators with less experience in running an

efficient infusion suite or with a limited understanding of how oncologists function. It is also important to ensure that supporting departments are willing and able to meet the oncology patients' needs. Will a new check-in or registration system bog down the flow? Can the laboratory turn around results in a timely manner? Will pharmacy be able to mix and deliver drugs without long patient wait times? Will there be formulary restrictions that affect the physicians' practice patterns? Can nonphysician practitioners function in a manner consistent with the physicians' needs?

Performance and Compensation Issues

When a practice turns over the infusion business to a hospital, the remaining physician revenue under today's fee-for-service system is essentially limited to professional fees. These fees are simply inadequate to cover a typical medical oncologist's income expectations. Thus, a new means of legally compensating the physicians, whether employed or engaged through a professional services agreement, must be devised. The best compensation agreements in our experience encompass three areas: clinical productivity, management duties, and what we refer to as "citizenship" expectations. For all of these, it is vital that both sides understand the specific expectations and the precise methodology for calculating total compensation. Total compensation must be at fair market value (FMV), although that term is not specifically defined in any of the laws and regulations. Therefore, before completing any compensation agreement, we recommend engaging an external source to validate the final amounts before a review by an appropriately knowledgeable attorney.

It is important to note that numerous laws and statutes preclude hospitals from paying physicians based directly on the volume of referrals they generate, on the volume of services ordered, or on the actual revenue or profit received for those services. This includes any margin based on 340B drug savings that the hospital may enjoy. Therefore, one must find another means of reaching a compensation figure that is defensible in terms of FMV.

In our experience, clinical productivity is best measured in terms of work relative value units (WRVUs). A variety of benchmarks is available for both the number of WRVUs and the dollar value of those WRVUs. Be aware, however, that the vast majority of benchmarks for number of WRVUs are difficult to apply to oncology. This is because there are WRVUs associated with the administration of drugs, but those services are likely impossible to attribute to a specific physician or physician group in the hospital outpatient setting because there are generally numerous other physicians who refer nononcology patients to the infusion center. Therefore, the volume benchmarks need to be adjusted if they are to be used as part of the measure of productivity. Recently, we have seen that roughly 13% of a private practice physicians' WRVUs are associated with drug administration.

In addition to WRVUs, physicians should look for contracts that compensate for more than clinical production. If the physician/group will be responsible for a defined set of management

duties, there should be compensation for that work, often measured in hours spent and paid at a FMV hourly rate. (Comanagement agreements are also a factor, and, although outside the scope of this article, the terms for those carry their own requirements.) Further, if physicians are expected to play a leadership role for the hospital's cancer program—chairing a committee or performing specified marketing activities, for example—that time should be compensated. Finally, we believe that all compensation components should include incentive opportunity, whether in terms of clinical production or of qualitative performance such as patient satisfaction. Our recommended approach is to construct agreements that include a base target or threshold measure with incentives for exceeding targets. In any case, the agreement also needs to protect both the physicians and the hospital with reasonable floors and ceilings, and should include a defined timetable for updates (often annual) and for overall revision (usually every 3–5 years).

When a hospital compensates a physician for his or her services, there must be a funding source that will support the compensation. If the hospital is not up to speed on the details of billing and collecting for infusion services, the funding source may suffer, and the hospital may seek to reduce compensation. Before agreeing to any compensation agreement, both parties should be satisfied that processes are in place to ensure optimal financial performance. We encourage both physicians and hospitals to take maximum advantage of the capabilities and expertise that each brings to the table. These include highly specialized billers, infusion nurses, and schedulers from the practice side, and capital dollars on the hospital side.

Other Issues

One of the concerns we frequently hear from physicians is that the patients will pay more under the new structure. Sadly, this may be true because hospitals are significantly more expensive to run than are private office practices. The benefit to the patients is that they have access to a far greater array of nonbillable support services (social work, nutritionist, and so on) and that unfunded or underfunded patients may have access to a variety of other assistance programs and charity care.

Another issue that sometimes arises relates to insurance contracts, at least under the current reimbursement system. In many cases, payers offer better terms to hospitals for outpatient services than they offer to practices. A shift of care to the hospital side may spur the payer to "push back," and this possibility should be factored into the financial projections before completing the deal.

Once the alignment agreement is finalized, the operational challenges continue. The single largest challenge in our experience relates to information technology (IT). Sometimes the practice is far more advanced than the hospital, or vice versa. More often than not, both have a variety of IT systems in place, and merging or migrating them can be an enormous task: scheduling systems, chemotherapy ordering, electronic medical records, billing systems, and so forth. Further, the hospital's systems are rarely oncology specific, and decisions have to be made regarding the trade-off between decreased functionality

and increased cost to run potentially duplicative systems. Again, both sides must be prepared for this journey, jointly selecting the best option when systems do not integrate (especially when it comes to chemotherapy orders) and recognizing that this transition may take a very long time, that it may require numerous interim processes for incremental implementation, and that allocating adequate resources to accomplish the changes is crucial.

Additional challenges can stem from a variety of regulatory requirements, particularly where facilities are involved. Although the USP 797 rules for pharmacies technically apply to all settings, most practices have not been able to afford the expense of updating the pharmacy space. The Joint Commission, along with many state Departments of Health, has specific facilities requirements for hospitals, such as width of hallways and number of handwashing sinks, that private office spaces may not meet. In some cases, we have seen alignment projects delayed for lengthy periods until funding or other arrangements can be made to permit the provision of infusion services under a hospital's license.

Summary

In short, the general health care environment in the United States is driving a shift from office-based to hospital-based out-

patient infusion services as all parties seek ways to provide care in a more cost-effective and efficient manner through accountable care organizations, medical homes, shared savings programs, and more. As physicians and hospitals are driven toward working together, the devil is in the details. Both sides must examine all aspects of the change at every level to ensure the smoothest transition possible through open communication, clarity and specificity of details, realistic expectations, and transparency throughout.

Author's Disclosures of Potential Conflicts of Interest

The author(s) indicated no potential conflicts of interest.

Corresponding author: Teri U. Guidi, MBA, FAAMA, President & CEO, Oncology Management Consulting Group, 241 Smithtown Rd, Pipersville, PA 18947; e-mail: tguidi@oncologymgmt.com.

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