The Economics of Oncology: Doctor-Hospital Integrated Practice

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The doctor-hospital integrated practice is one possible strategy oncologists may wish to employ in order to stay financially solvent in the current unstable health-care environment. Before entering into an arrangement with a

Introduction

The managed-care revolution has had unprecedented effects on the traditional practice of medicine. The combined purchasing power of large employers paved the way for all types of health insurance purchasers to band together to cut premium costs. Over the last 4 years, this march toward economy of health-care delivery has had a dramatic impact on some health-care providers, especially doctors and hospitals.

Many medical specialists have seen their incomes drop by 33%. More importantly, many hospitals have seen their revenues disappear. Not only are hospitals being pressured to drop per diem rates, but hospital utilization is being hammered by case management and primary-care capitation. In this unstable environment, what strategies should a medical oncologist consider in determining a future course for his or her practice? This paper looks at one such strategy—the doctor-hospital integrated practice.

Before selecting any future direction, the medical oncologist/hematologist should assess his or her current situation and professional goals. Key issues to consider fall into four categories:

1. financial capital
2. access to patients
3. practice quality
4. intellectual satisfaction

Financial Capital

Finding financial capital needed for practice growth is one of the most difficult hurdles physicians face in the 1990s. Since the passage, in 1993, of the "Stark" anti-kickback laws, physicians are essentially prohibited from investing in local medical systems other than their own practices. Banks that were formerly generous now require extensive personal collateral that could put the individual practitioner at risk.

Separate and distinct from the federal anti-kickback statutes is another impediment to physicians gaining access to working capital—the federal antitrust regulations. These rules limit how closely, and under what structures, physician groups can pool resources.

Evaluating the Hospital's Financial Health

Working capital may still be available, however, from a hospital. Before a physician decides to "bond" with a local hospital, he or she should carefully evaluate the institution's financial health and, if applicable, its affiliations.

National standardized measures of a hospital's health are available from large accounting firms, such as Peat Marwick. These standardized measures can be used to compare the hospital in question to other similar institutions with respect to profitability, reserves, and working efficiency. The physician should not accept a hospital administrator's assurances that the money is there and available. Rather, the physician should obtain these reports for an objective analysis of the hospital's strengths.

Forging an Agreement

Once the oncologist confirms that the prospective hospital partner does indeed have capital, he or she needs to secure a contractual agreement that specifies what resources will be expended to fulfill the needs of the oncology practice and how soon this will be done. Just because a hospital has
investment capital available, there is no assurance that it will invest that money in a cancer program. The hospital could change its direction and invest in other areas that would help it survive in the new marketplace, such as mental health, long-term care, and primary-care practices. The contract should include specific commitments from the hospital and a timetable describing when they would be implemented.

**Access to Patients**

The second critical area that the physician should consider is where the patients will come from. If a physician enters into a relationship with a hospital (the various types of which will be discussed below), how will his or her present referral patterns change? The physician who becomes an employee of one hospital in a community that fails to capture a large managed-care preferred provider contract will not see those potential patients. If the physician is not employed by the hospital, but has an office on the hospital campus and the chemotherapy drugs are provided by and billed for directly by the hospital, he or she also may be excluded from new referrals for the same reason; namely, the hospital partner may not be the preferred provider for any outpatient or inpatient services.

**Reviewing the Hospital's Managed-Care Contracts**

Before forming a relationship with any hospital, the physician should review the institution's current managed-care contracts, specifically looking for how many insured lives in its service area are covered and what is the duration of the contract. If time permits, the practitioner also can contact the corporate benefit managers of those employer groups and query them on their degree of satisfaction with the hospital contract. This "investigation" may reveal that an employer group is planning to switch hospitals at the next contract renewal time.

**Practice Quality**

The physician also needs to think about the type of practice he or she wants. Does the clinician want to work as hard as possible, or set up an 8-hour-day, 4-day-week schedule? Issues such as workload, type and amount of ancillary staff, and choice of associates will change if the practice is blended with a hospital.

The most critical question is, to whom do the patients "belong"? If the patients belong to the physician, if their medical records are owned by the physician, and if they can follow the physician if he or she leaves the hospital, the physician will have an incentive to work hard and strive for a high level of patient satisfaction. If, on the other hand, the patients belong to the hospital or vertically integrated health-care system, the physician may still provide great care, but the reward for that effort is less direct or immediate.

Similarly, when patients belong to a "system," the repercussions arising from low patient satisfaction may never reach the physician responsible. Also, decisions about adding doctors or other staff are made on the basis of what is good for the system as a whole. Likewise, if the patients belong to the hospital, how hard the physician works will be directed by policy rather than by the physician's determination of need, as is the case in a private practice.

**Intellectual Satisfaction**

A final issue to consider is whether the arrangement will offer the intellectual satisfaction that the physician seeks. Many hospitals have the resources to enable an oncologist to perform clinical research with the help of an on-site data manager. Funding for such capability can come from NCI research grants (CCOP [Community Clinical Oncology Program], CGOP [Clinical Group Outreach Program] and also from pharmaceutical research programs or hospital endowment funds. Such a research effort can help the physician provide state-of-the-art care and keep him or her abreast of new treatment options.

**What Hospitals Look for in a Physician**

What should the hospital administrator look for in determining whether a physician is a good partner for that institution? Currently, there are between 6,000 and 7,000 active practicing oncologists in the United States. Even though this is a small number that will not increase significantly over the next decade, it behooves the hospital administrator to be just as cautious as the physician when selecting a partner. Certainly, the physician must be credentialed as an active member of a hospital staff,
without any privilege restrictions. The clinician should have completed an approved fellowship training program and should be board certified in medical oncology and/or hematology. He or she should have the trust and respect of referring physicians. The physician also should have leadership capability, as evidenced by participation in medical society, hospital staff, or tumor board activities. Ideally, the prospective partner should demonstrate a desire to provide high-quality, state-of-the-art care through national clinical trial programs. These characteristics will predict that if all the incentives of the hospital and the physician can be properly aligned, the joint cancer program will be successful.

**Types of Doctor-Hospital Relationships**

After the physician has accurately characterized his or her practice aspirations, the next step is to examine the menu of possible doctor-hospital relationships.

**Simple Purchase of the Practice**

The easiest to consider is a simple purchase of the practice by the hospital, with the physician then becoming an employee of the institution. The physician's salary may be a fixed amount or proportional to clinical service billing volume. Charges for laboratory services, chemotherapy drugs and supplies, and chemotherapy administration would be billed by the hospital. The physician would be required to participate in the same retirement plan as other hospital employees. Malpractice insurance may or may not be provided.

This plan affords security, predictability, and initial risk avoidance. Since the physician would no longer have any overhead expenses, even major fluctuations in patient volume would have only a modest financial impact. Certainly, if the environment changed and the hospital decided to get out of the oncology business, it could shut down the program and, within the bounds of the doctor's employment contract, terminate him or her at some point in time.

Usually, under this type of agreement, the patients are considered to belong to the system, and the hospital may include a restrictive covenant that prohibits the doctor from seeing those patients for a set period of time if he or she left the hospital. The legality of this restriction is currently being tested in an Illinois court.

**Renting a Hospital-Financed Cancer Center**

A second option does not require the physician to relinquish his or her private practice. The hospital invests the capital to build a cancer treatment center and hires the staff; the clinician rents the space from the hospital at a fair-market-value rate and reimburses the hospital for the cost of the staff, including benefits. Under this type of arrangement, either the hospital provides the chemotherapy drugs and bills for them itself or the physician takes on these responsibilities within his or her practice.

Physicians deciding whether to enter into this type of relationship need to consider three rules. The first is the "incident to" rule of Medicare, which requires that if a physician is going to bill for chemotherapy, the patient must receive it in the physician's private office, administered by the physician or a nurse employed by him or her and directly under his or her supervision.

The second rule is the Ethics in Patient Referral Act, which prohibits self-referral for Medicare-covered clinical laboratory services. This means that if the physician uses a hospital laboratory, he or she must maintain an "arms-length relationship" with that laboratory. Alternatively, a laboratory within the cancer center would need to be wholly owned and operated by the physician and employees, not by leased employees.

The third rule refers to employee retirement benefits. The Internal Revenue Service has recently determined that leased employees are entitled to the same level of retirement benefits as full-time employees of the doctor's professional corporation. This means that if the physician's laboratory technicians and chemotherapy-certified nurses receive a 12% contribution to their pension and profit-sharing plan, the physician must ensure that the leased employees receive a financially equivalent retirement package. If the leased employees only receive a 4% contribution from the hospital to their 401K plan, the physician is responsible for setting aside in each of their names an additional 8% of their hospital salary in the practice's pension and profit-sharing plan.

Despite all of the restrictions, this model allows the physician to benefit from the capital infusion of the hospital and yet retain maximum practice independence. The hospital benefits from having an oncology service on campus, from rental and lease revenues, and from an increased use of therapeutic and diagnostic radiology services.

**Hybrid Model**
The third option is a hybrid of the first two, with some additional features. The hospital forms a separate corporation that employs all of the personnel, including the medical oncologist, nurses, pharmacist, administrator, and laboratory staff. All revenues from patient-care activity would flow to this separate entity. The hospital receives rent for the facility and its equipment. The entire staff is given a salary plus an incentive component based on productivity and patient satisfaction. A budget is established that allows for the growth of a financial reserve plus an incentive pool to be distributed to all the employees based on the profitability of the center. The amount of each employee’s distribution is determined by the productivity and satisfaction scores that employee earns, as compared with an established target.

Such a system would be able to accurately determine the actual cost of delivering care, thus making this type of doctor-hospital relationship competitive in the capitated health-care marketplace. The same structure could be broadened to include radiation therapy, therefore allowing for a capitated contract that would almost completely encompass the active treatment portion of oncology care. This entity could then contract with the hospital for a daily bed rate, and with hospice and home health-care services for a case rate. At that point, this hybrid entity would be able to efficiently manage the entire oncology disease for that service area.

Summary

In summary, the linkage of the medical oncologist to a hospital's cancer program can be a successful venture for both parties. If the hospital is willing to expend the capital and management expertise and if the physician wants to create a high-quality program, both will be happy. If one party or the other is looking for an easy way out of the competitive marketplace, the venture will not be successful. The only certainty is that both the science and business of health care will change, hopefully in ways that will lead to better patient care.

References:
1. AMA Legal Advisor, 1995.

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