

Economy Forcing Oncology Groups to Adjust Business

Introduction

The latest economic downturn has hit the entire oncology care continuum—medical and diagnostic imaging centers, community oncology practices, and patients. According to 23 oncology administrators who responded to a survey we conducted, new cancer patient volume was down 5% to 10% in many US markets in the first half of 2009. Reductions appear to be regionally-driven and are possibly due to loss of healthcare benefits. In Columbus, OH, for example, patient volume was down about 5% across the continuum; in Pittsburgh, PA, down 10%; and in Charlotte, NC, new patient volume appears to be stable for many groups.

The downturn is forcing cancer centers and community hematology-oncology practices to take a leaner approach to business.

Although new patient volume rebounded to mid-2008 levels for most oncology practices by May or June of this year—perhaps due to the possibility that those without jobs and healthcare benefits may have returned to work, or that those delaying a doctor visit over the winter saw a physician—administrators have continued their lean operating ways. The major concern for providers is that high deductibles, health plan policy changes, and looming inflation will make capital and staff investments increasingly difficult, and will increase the number of patients presenting at more advanced stages of cancer.

Table 1, at the end of this article, details how new cancer patient volume has changed due to the economic recession for the 23 practices. We took a closer look at 5 of those practices.



Practices

By Bryan Cote

Mid-Ohio Hematology Oncology

Mid-Ohio Hematology Oncology, the largest physician-based cancer care provider in the Columbus, OH market operating as the Zangmeister Center, averages about 320 new patients a



Glenn Balasky,
Executive Director,
Zangmeister Center

month and approximately 6,000 patient visits monthly. These numbers began to decline in November 2008, according to Glenn Balasky the group's executive director.

“Compared to the first quarter '08, we were off 4% to 5% in the first quarter of '09,” he said. “As a result, we watch our financials month to month, and hold ourselves accountable against a financial target plan—things we didn't do as aggressively before this year.”

In January, Mid-Ohio turned to a 4-day work week, and staff typically participates in 9 to 10 hour days with nurses averaging 8 to 9 treatments per 8-hour shift. Friday schedules are abbreviated. This change has reduced overtime and staff hours in the first half of '09, and according to Balasky, is leading to about \$300,000 in annual savings. “We realized,” he said, “we

could add hours on Fridays as volume picked up.”

As of this issue, the group has not yet had to do this—a sign that the economic downturn hasn't exactly reversed itself. Additionally, the savings are more than offset by other balance sheet concerns. For instance, patient balances—the amount owed the practice including co-payments and uncovered services—are up 20% in the first half of '09 compared with the same period last year. “We're managing accounts more aggressively, asking for payments upfront, but it is harder to close the gap because people have lost jobs or have incurred significant debt,” he said. [cont. on pg 22 >>](#)

*“The struggle of today is not altogether for today
—it is for a vast future also.”*

Abraham Lincoln, first annual message to Congress; December 1861

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Use of co-pay or drug assistance programs are up about 40% to \$70,000 a month versus the same time last year; and Mid-Ohio doesn't receive payment for the time involved in tracking down drug assistance, so staff time has increased to meet this demand. In order to reduce costs, the group shops more aggressively for other sources of drugs at lower costs, and for lower drug prices—even a 20-cent savings on generics in one case. Furthermore, they've negotiated \$60,000 in savings in disability insurance, and saved \$16,000 in supplies by calling vendors directly.

"I've learned that we can recover from volume drops," says Balasky, "but retaining staff may be far more difficult in a few years if inflation goes up or if payers push to renegotiate contract rates closer to lower Medicare levels. This is what keeps me up at night."

Carolinas Hematology-Oncology Associates

Unlike Mid-Ohio, new patient volume has remained relatively stable since October at Carolinas Hematology-Oncology Associates in Charlotte, NC. The group says

it is shielded in part by its health system affiliation with the Carolinas HealthCare System, but with an influx of seniors entering what is still a growing southeast market, oncology practices here typically should expect steady incremental growth, says Judy Stone, the group's director of Single Specialty Oncology Practices.

Stone said that the downturn surfaced in the Carolinas group in subtle ways including an increase in indigent and underinsured patients and large upfront deductibles. Patient drug assistance was three times higher in the first five months of '09, compared with the last five months of '08, she explained.

To manage the economic impact on the group, Carolinas Hematology-Oncology addresses cost issues upfront with new patients—an approach that began at the end of last year. "We're now looking at [patients'] benefits upfront to see if they have a big deductible—if the insurance plan only pays a portion of the treatment, we let the patient know so they can prepare."

Stone reassures that the group treats all patients the same despite the variations in reimbursement between Medicare and commer-

cial payers. "We look at our Medicare population and while we might be a little underwater on a drug, we give Medicare patients a virtual discount, because there's less to do administratively than those with managed care plans. We don't discount the services we just accept that we lose a little on the drug but make it up by not having to pre-certify treatment or authorize visits."

Stone says that patients with odd payer policies that limit the amount of benefit dollars for chemotherapy are on the rise. In one case, she said a patient opted for outpatient chemotherapy treatment and then realized her plan only covered inpatient treatment.

Through its affiliation with the Carolinas HealthCare System, the practice has access to an indigent clinic and a 340B program, but the clinic is overflowing so the practice is also looking at other ways to take care of the increasing number of uninsured or underinsured.

"A greater problem, however, is that fewer patients are seeing their primary care physicians," says Stone. "This tells me that we will begin to see more and more patients who come



to us sicker because they have waited too long to see their PCP.” That’s the future effect of the economic climate Stone is most worried about.

Dana-Farber Cancer Institute

Urban medical and academic centers are also concerned that the economy and/or job loss is forcing people to delay doctor visits. According to Susan Buchanan, MS, PA-C, adult leukemia physician assistant at the Dana-Farber Cancer Institute, Boston, MA, a 5% to 10% decrease in new patient consults for adult leukemia is being noticed as well as fewer second opinion consults (perhaps due to travel expenses). Furthermore, she is noticing an increase in Medicaid patients from New Hampshire and Maine—two states severely hit with unemployment since December.

“Leukemia symptoms like bruising don’t always show up, so with PCP visits down due to the economy, there have been fewer physicals, which means fewer CBCs ordered—reducing the likelihood that a physician could catch any abnormality,” she says.

Buchanan and her physician colleague are used to seeing four new patients a week, about half for myelodysplastic syndrome (MDS). “These numbers have remained relatively steady since patients often request my MD, but overall for the four physicians in our group, visits were down.”

Interestingly, Dana-Farber is seeing growth in the number of complex cases for rare leukemia and bone marrow transplants—the result of

commercial payers’ policies to encourage physicians to refer these types of cases to institutions with larger volume and more developed infrastructure and expertise. This growth at Dana-Farber has off-set some of the dip on less complex cases. “It tells me,” says Buchanan, “that our new patient volume would be much lower than the five to ten percent without these cases.”

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In some ways, treating patients with MDS has become more difficult in the economic downturn since patients, and some doctors, are either uneducated about MDS or are faced with a difficult financial decision, says Buchanan.

For instance, according to an article in the *Wall Street Journal*, the cost to use Revlimid [lenalidomide; Celgene] per month is significant for seniors with Part D benefits as those patients hit the catastrophic cap almost immediately; and unless they can get patient assistance, are forced to pay a

large portion out of pocket (*WSJ*, July 1, 2006). “This is a lot financially to bear for a treatment that is not guaranteed to provide a patient benefit,” says Buchanan, further adding that Celgene has been very generous with patients who can’t afford the drug.

Alternatively, Vidaza [azacitidine; Celgene] and Dacogen [decitabine; Eisai] are two other treatment options indicated for those with MDS, but some community physicians, says Buchanan, have not given Vidaza enough time for proper trial efficacy.

“Based on the CALGB clinical trial data presented by L. Silverman in 2006, and in our experience, patients need four cycles, one per month before we compare bone marrow results to baseline. Unfortunately some oncologists who don’t see blood count improvement after two cycles stop the course and try something else,” she said.

Buchanan thinks patients are less likely to stop Vidaza or Dacogen treatment for financial reasons since these injectables are delivered under a hospital Medicare Part A or in-office Medicare Part B benefit.

UPMC Cancer Center

For the UPMC Medical Center located in Pittsburgh, PA, new patient volume was down 5.6%, and all office encounters were down 6.2% from the third quarter 2008 through the first quarter 2009, says Peter Ellis, MD, Deputy Director, Clinical Services, Associate Chief Medical Officer.

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According to Ellis, this is the toughest quarter-over-quarter revenue drop he's ever seen. "We were back up a little in March and April, but back down a bit in May. We talked to our peers in other markets and they're experiencing similar reductions," he said. UPMC is continuing to track volume over the summer months.



Peter Ellis, MD, Deputy Director, Clinical Services, Associate Chief Medical Officer, UPMC Medical Center

Ellis says that it's not that patients are delaying treatment, it's that they aren't getting screened, which is leading to lower referrals. "This tells us that if the economy improves, we'll see a bubble of volume on other side."

Since the fall of '08, UPMC has had two staff downsizings but no cancer care staff reductions. "Recruiting and retaining highly-trained oncology nurses is costly," says Ellis, "so we stayed put and did less rehiring of some positions."

They've also put capital investment on hold. UPMC relies on revenue for capital upgrades, new diagnostic technology, and oncology-related equipment, but the dollars aren't there to support these types of investments. To manage the downturn, UPMC continues to rely on a clinical pathways program to drive standardization of evidence-based care.

Four pathways will be added soon—one each for uterine, thyroid, bladder and gastric cancers—totaling 17 pathways for the center. According to Ellis, physicians at UPMC follow pathways about 91% of the time. In cases where there are equally efficacious treatments, UPMC is looking more now than before for the more cost-effective treatment, perhaps the generic.

Conceivably, Ellis thinks the recent volume drop this year will precipitate greater investment in evidence-based standardization. "We expect the economic challenges to force consolidation of smaller practices who can't standardize or don't have capacity to put those systems in place," he contends. UPMC has been working with Senator Kennedy's staff on a cancer care bill pilot that may include a pathways pilot.

Decatur Memorial Hospital-Cancer Care Specialists

Asking staff to do more this year than in previous years, Decatur Memorial Hospital in Illinois has cut overtime hours overall and operates on a flex budget in response to slightly lower volumes, says John Ridley, executive director of oncology services. "It's a style of budgeting that works for cancer care as our volumes ebb and flow, so we're prepared to ramp up as volumes restore," he said.

Interestingly, unlike UPMC, Decatur is not trying to hold back on capital investment as it builds a new joint venture cancer center. "For the center, we feel we can't cave in on all the plans." Moreover, Cancer Care Specialists of Central Illinois, a 15-physician medical group, will own the 55,000 square foot building, with Decatur as the tenant.

"This is kind of 180 degrees from a conventional set up," says Ridley. "But in this economic time if you have an oncology practice where you're geographically fragmented—with a piece at a hospital and another piece down the street—it makes it tough to do business." In this new setting, the physicians can have face time together, he said.



Conclusion

In as much as we would think oncology administrators would like to turn the page on this economic period, they aren't. In fact, most are embracing these lessons as a new business model for cancer care—one that will help practices confront reimbursement changes, healthcare reform, inflation, and the inflation, and changing patient volumes. **BC**

KEY POINTS

As new cancer patient volume restores to mid-2008 levels, there are some important business lessons to take from the 2009 economic downturn:

- Flexible staff schedules and budgets can save money quickly without sacrificing access and care.
- Retaining nursing staff is critical, given the high cost to recruit and train.
- Tracking financials more often and monitoring vendor costs more aggressively are critical to reduce expenses.
- Joint ventures and health-system affiliations can reduce the effects of a recession.
- Evidence-based pathways may be a viable approach to reduce costs and improve outcomes.
- Increase financial conversations with patients—practices must find sensitive yet effective methods of discussing treatment costs with patients and asking for payment upfront.

Table 1. Changes in New Cancer Patient Volume (Nov '08-Mar '09).

City	Oncology Provider Type	Avg. Monthly Volume Change
Columbus, OH	Community	(Nov 2008 through March 2009)
Columbus, OH	Hospital	-5%
Hartford, CT	Hospital	-10%
Hartford, CT	Community	-12%
Detroit, MI	Community	-5%
Seattle, WA	Community	-10%
Seattle, WA	Cancer Center	-8%
Charlotte, NC	Community	-5%
Charlotte, NC	Cancer Center	-1%
Boston, MA	Cancer Center	Flat
Boston, MA	Community	-12%
Indianapolis, IN	Community	-5%
Indianapolis, IN	Hospital	-3%
Pittsburgh, PA	Cancer Center	-10%
Pittsburgh, PA	Community	-10%
Dallas-Ft. Worth, TX	Community	-4%
Dallas-Ft. Worth, TX	Hospital	-9%
Dallas-Ft. Worth, TX	Community	-15%
Tampa, FL	Community	-7%
Decatur, IL	Community	-5%
Decatur, IL	Hospital	-8%
Denver, CO	Hospital	-10%
Denver, CO	Community	-7.5%
Average	All	-7.24%
Average	Hospitals and Cancer Centers	-10.15%
Average	Community	-5.77%