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Opportunities for Radiation Oncology

by Harold B. Wodinsky, M.H.Sc., and G. Stephen Brown, M.D., F.A.C.R.

Since the introduction of radiation therapy, its use has grown to include treatment of many common cancers, such as breast, lung, rectal, and prostate cancers. In fact, radiation therapy (curative, palliative, adjuvant) is considered by many to be clinically appropriate in at least 50 percent of all newly diagnosed cancers. Radiation oncologists are recognized as an integral part of multidisciplinary cancer care and make up a significant part of the physician work force dedicated to treatment of malignant disease.

The last ten years have seen significant changes—and increasing pressures—in radiation oncology practices. The primary model for care shifted from hospital-based to dedicated freestanding (outpatient) radiation therapy facilities, creating a new breed of physician entrepreneurs. Suddenly, radiation oncologists who traditionally relied exclusively on reimbursement from professional fees (approximately one-third of all charges) began receiving global compensation and found no lack of financial investment support from local hospitals, venture capitalists, or banks. The number of megavoltage accelerators grew significantly as certain states relaxed their certificate of need requirement. Although there were few associated changes in patient survival, new technology provided a better quality of radiation treatment and greater symptom control. Because cancer is predominately a disease of the elderly (more than 60 percent of cancer cases will be in the population 65 years and older), Medicare represented the largest payer for cancer services and was a generous "insurance company" for many years. Along with these changes came a dramatic increase in the cost of radiation oncology care.

The American Medical Association's Common Procedural Technology (CPT) coding system was adopted by the Health Care Financing Administration (HCFA) for reimbursement in 1983. With the coding system came increased scrutiny of total expenses and the variability in payments. In 1985 and 1986, HCFA and Congress became more concerned about the rapidly rising cost of Medicare. Four years later the resource-based relative value scale (RBRVS) was introduced, and the subspecialty "radiation oncology" began to experience decreases in relative reimbursements, estimated at an 18 percent loss by the time implementation was complete.

A CHANGING LANDSCAPE

Numerous factors have led to a decrease in available practice revenues. Physician ownership has been challenged by Stark self-referral legislation and research suggesting that an ownership interest may increase referrals. Increased scrutiny and more regulation have resulted in increasing practice overhead costs. Laissez-faire, fee-for-service reimbursement gave way to case management and utilization review, a relative value scale payment scheme, and rapid growth in managed care companies and increased penetration of managed Medicare.

Managed care organizations realized that the new freestanding radiation therapy centers, free of hospital overheads, offered deep discounts in charges. Seeking cost predictability, managed care companies pushed the development of case (bundled) rates in radiation therapy, which are a harbinger of capitation arrangements. In some places, managed Medicare has resulted in decreases of 15 to 20 percent over traditional fee-for-service income.

Although still common, Medicare fee-for-service reimbursement for radiation oncology is also under pressure; weekly management fees are rumored to be halved in the next two years. Record numbers of residents in radiation oncology graduated, resulting in an oversupply of professionals and further exacerbating the pressure on incomes. Physician extenders are now finding their way into radiation oncology practices.

Radiation oncologists rely almost exclusively on referrals from other practitioners, primarily general surgeons, urologists, and medical oncologists. These traditional relationships have been challenged by the new care paradigm: Managed care companies are reaffirming the pivotal role played by primary care providers and the radiation oncologist's traditional ally, the medical oncologist, in triage and controlling the costs of care. Anecdotal reports suggest that in heavily "managed" cancer regions, referrals of newly diagnosed patients for radiation therapy fall below the 50 percent range, approaching 35 percent.

The pressures are mounting to

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modify treatment to conform with the changing standards. Patients who would have received a palliative course of therapy now receive shorter courses of therapy or analgesics and narcotics for pain control. Capitation may ultimately result in a decrease in the length of a course of radiation therapy treatment, where such a decision does not have a direct bearing on patient morbidity or survival. When dealing with capitated patients, urologists may defer radical prostatectomy in favor of a radiation therapy. There are also the issues of age bias in treatment and its potential effects on managed Medicare. Routine, post-therapy follow-up visits to a radiation oncologist may be denied by a primary care physician whose medical group takes full risk for a patient's care from the HMO.

Oncology is noted for its variability in treatment styles, appropriately called "clinical judgment." There is seldom a single correct answer to a medical problem. The vigorous development by several complementary groups of clinical pathways and other tools that purport to document the range of appropriate alternatives for clinicians has captivated the attention of the clinical community. Radiation oncologists are not exempt from this initiative. The evolution of disease management systems, sophisticated case management tools that outline treatment guidelines, may have a profound effect on the way we practice. The disembodied voice evaluating whether care can or cannot be given will now have added tools at its disposal.

Managed care companies are reluctant to pay more for the traditional aura of excellence associated with some practices unless they can see improved quality, defined in terms of outcomes and patient satisfaction. They are also taking steps to reduce inappropriate treatment or overutilization. "Demand management," for example, is a newly coined term by managed care organizations. It refers to the development of patient information technology theoretically designed to convince health care consumers of the range of appropriate alternatives for their condition. In other words, reduce inappropriate demand by patients and replace it with clinically driven need. The hypothesis is that physicians will perform fewer procedures if the patients stop demanding them. One conclusion is that when individual patients are presented with options, rational choices will depend on attitudes about risks and benefits.

Market evolution also has an impact on once-comfortable surroundings. Unstructured landscapes with little consolidation have given way in more densely populated areas to hospital consolidations, physician hospital organizations (PHOs), primary care and large multispecialty practices, other provider networks, and independent physician associations (IPAs). All are vying for managed care lives.

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Furthermore, in a mad rush to reduce overhead and strengthen market position, the number of solo practitioners moving into group practices has never been higher.

The oversupply of practitioners is not a myth, and with a glut of providers, disenrollment can indeed occur. Physicians live in fear of disenrollment by managed care companies who seek exclusive partnership. Exclusive partners are aggressive, clinically appropriate, well-connected politically, and more willing to take lower compensation for greater volumes of patients.

State initiatives are also flawed. Relying on legal support from "any willing provider" legislation may be premature; many state regulations permit managed care organizations to define the maximum number of any specialty group required to fill the regional need and consider an application only when their insured population grows or when there is attrition in the physician ranks.

While some oncologists have resisted capitation, managed care organizations will be patient. The awaited cancer carve-outs or carve-ins have emerged despite indications that most larger insurance companies are reluctant to use this model. These entities include assigned risk for 1) all inpatient and outpatient services, 2) outpatient oncology services alone, and 3) only the professional component of outpatient oncology services. High-quality and low-cost providers are going to survive.

Even insurers are not immune to the competitive pressures. Recently there has been a growing consolidation of insurance companies as the industry enters a period of natural selection. Premium wars are sure to follow and with them further decreases in reimbursements.

These trends are not intermittent breezes, but the prevailing winds of change! No radiation oncologist should think they will go away. While there have certainly been some remission and decrease in intensity, the general direction of insurance-initiated health care reform is clearly not likely to deviate dramatically.

WHAT IS RADIATION ONCOLOGY TO DO?

There are several alternative strategies for thriving on chaos. The key is to recognize that every market is unique and every circumstance different. Choices abound. Most radiation oncologists, depending on where they are in their practice's life cycle, market position, and competitor status, may opt to:

1. Stay in solo practice and ride out the storm until retirement (a 55-plus strategy).
2. Form or join an IPA or MSO that is multispecialty, all-oncology specialist, or radiation oncology-exclusive.
3. Join a PHO.
4. Join a PPO.
5. Sell all or part of the practice to another radiation oncologist, a multispecialty group, a hospital, a medical school, or a physician practice management company. (Again, that physician practice management company may be multispecialty, all-oncology specialist, or

radiation oncology-exclusive.)
6. Buy a competitor or establish another practice.
7. Become an employee of an HMO.

With the exception of the first alternative, the common denominator in these choices is the strength gained from developing an alliance with other individuals. Loss of business independence, governance issues, lifestyle changes, the difficulty of finding someone with a shared vision, exclusivity, reimbursement, and the need for clinical autonomy all factor into the decision-making process. Equally important is talking with colleagues and former competitors about opportunities for collaboration. Selling a practice may be the wrong answer to the specific local or regional challenges. A more appropriate initial response may be to join those entities that provide for enhanced contracting skills, promise the managed care companies more geographic coverage, and are a minimum cost to the practice, such as a PPO or PHO.

Many radiation oncologists are reluctant to attempt new development or acquisition in this business climate. Although still available, backers for such ventures are dwindling because record returns of investment are known to be a thing of the past. However, privately owned radiation therapy networks, both hospital-based and freestanding, are not new to the industry. There are obvious advantages and economies of scale to these networks, since such areas as office functions, the maintenance and repair of megavoltage equipment, physics support, and treatment planning can all be centralized.

A key reason that management services organizations have been developed is to reduce costs by consolidating overhead functions. Although the new skill of negotiating contracts with managed care companies can be acquired, mounting practice pressures make it increasingly difficult to find time to become proficient in this new art form. On the other hand, IPAs may have a sophisticated managed care organization strategy but have been criticized for bringing insufficient capital resources to accommodate information technology requirements. And there are large numbers of network "wannabes"; radiation oncologists need to beware the vapor that follows empty promises.

An anxiety common among radiation oncologists is that as medical oncologists establish or join networks, they will successfully control an increasing share of radiation oncology referrals. However, developing a designated relationship with one medical oncology practice can lead to alienation of other sources of referrals, such as that practice's competitors. There may be good reason for this concern. With the advent of national cancer physician practice management companies, there has been increasing enthusiasm for evaluating the so-called cancer carve-outs, in conjunction with managed care organizations, and awarding risk and reward for the cancer care to these companies. There are also specific regional phenomena where cancer-specific IPAs (including multiple radiation oncology practices) have been formed, seeking the same exclusive relationships with managed care companies. Notwithstanding the potential antitrust issues in any such venture, the current evidence regarding cancer carve-outs suggests that generally managed care companies are very cautious about their use. In more mature managed care markets, a more established alignment is for managed care organizations, whenever possible, to put the primary care physicians at risk for all care and allow them to develop relationships and payment schemes with specialists of their choice. This can leave the radiation oncologists having to go door-to-door to secure referrals. In other markets, the risk for all care, including cancer, has been shifted to coalitions of providers and hospitals, or so-called super PHOs.

Cancer is at a relatively low incidence in commercial (i.e., non-Medicare) populations. It is nevertheless important to establish firm relationships in anticipation of the advent of a managed Medicare plan. Managed care organizations are unlikely to assign risk to any provider group unless they have a strong indication that patient and primary care physician satisfaction will not be compromised. No managed care organization can afford the public or regulatory scrutiny that could result if the opposite were true.

The radiation oncologist must weigh opportunities and challenges offered by these alliances. Being part of a national firm is not without risks; one oncology group found itself at odds with its local hospital after the group sold to a national firm. The hospital is considering recruiting new, hospital-based, alternative specialists. Most of these national companies are "medical oncologist as gatekeeper focused," which, while theoretically assuring referrals, could nevertheless put the radiation oncologists at a distinct "onco-political" disadvantage. Further, for hospital-based radiation oncologists (more than two-thirds of all megavoltage equipment is hospital based), professional services agreements are likely unassignable or can be canceled with minimum notice, leaving little to sell to the physician practice management companies. Besides, in developing the least expensive network, these companies would likely want to associate with freestanding radiation oncology centers whenever possible to reduce overhead issues.

Joining a PHO may be a foregone conclusion for hospital-based radiation oncologists. These organizations, however, have generally been limited to capturing only the hospital's self-insured population. Even then, cost pressures have led some PHOs to negotiate contracts with freestanding radiation therapy centers rather than the one located in the hospital's basement. Sale of a practice without sufficient continued employment guarantees or with restrictive covenants can also result in significant aggravation for the radiation oncologist. As employees, radiation oncologists may find themselves with diminished organizational status and may continue to face the prospects of under- or unemployment. Finding a partner who has a quality moniker, "market recognition," and staying power may not always be possible. Whichever partner is chosen, radiation oncologists must realize that their careers will be changing forever.

Whatever the strategy, the radiation oncologist must work quickly to determine the range of alternative right answers to the dilemma. Radiation oncology will continue to be an essential part of comprehensive cancer care. The future survivors will be limited to those providers who can furnish a demonstrable quality service at a cost within the economic limits of managed care companies and Medicare.