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# Radiation Oncology: HCFA's Proposed Changes to Practice Expense Regulations

by Lee E. Mortenson, D.P.A., and R. Larry White, M.D., F.A.C.R.

**R**ecently HCFA issued proposed practice expense regulations. The medical oncology community has been anticipating these regulations, given that HCFA committees were recommending that the undercompensation for chemotherapy administration be redressed. Medical oncologists have been significantly undercompensated for chemotherapy administration and subsequently have had to use chemotherapy margins to support the staff and other overhead costs to provide the service.<sup>1</sup>

Unfortunately, at the last moment, HCFA changed strategies and databases, opting to use the American Medical Association's Socioeconomic Monitoring System (SMS) survey data on actual practice expenses, rather than the information it developed over the past few years through its panels.<sup>2</sup>

The change in strategies and databases altered HCFA's approach from the "bottom-up" approach mandated by Congress to a "top-down" approach. A simplistic analysis of the effect of changing approaches and databases would be to say that many specialists lost ground, while general surgeons gained ground. In the case of medical oncology, HCFA's approach means that none of the ground

between the actual costs of providing the service and the lower level of compensation has been made up.

Of greater significance has been the impact on radiation oncology of the proposed practice expense regulations. HCFA's approach means dramatic reductions in payments. The impact on the professional, technical, and global components of radiation oncology will vary, as the practice expense value units comprise different proportions of the respective component's total payment. The professional component would be reduced 8 percent over four years; the technical component would be reduced 24 percent over four years; and global payments would be reduced 19 percent over four years.

As with most databases, AMA's SMS database was developed for an entirely different purpose. HCFA is using it for a secondary purpose, initially ignoring the fact that some specialties are underrepresented in the database. Radiation oncology is one of these specialties. Examination of the AMA database is still ongoing, but it is clear that the number of radiation oncologists that responded was so low that HCFA arbitrarily lumped their data with that from radiologists. Changing databases has resulted in 1) a sample of radiation oncologists so small it was unlikely to reflect reality and 2) a simplistic policy solution that makes radiation oncology one of the extreme outliers produced by switching methodologies.

The methodology might be questioned not only for its small initial sample of radiation oncologists, but also for its analysis of overhead costs. For those radiation oncologists who are part of a

multispecialty group, the entire group's overhead was requested, rather than just the specifics of the radiation oncology overhead.

## ANALYSIS OF PRO FORMA

To assess the impact of a 24 percent proposed cut in technical fees and current cost structures associated with radiation oncology, we asked the consulting staff at ELM Services, Inc., in Rockville, Md., to develop a series of *pro forma* for a standard radiation oncology center reflecting HCFA's proposals. We had three objectives:

- 1) determine whether a radiation oncology center with a reasonable Medicare patient load would be economically viable on an ongoing basis
- 2) determine whether any new radiation centers could be opened (Would the loss in fees be so great that the investment would no longer be viable?)
- 3) determine whether the returns on investment would be so low that radiation oncology centers would not be able to replace equipment. (In effect, would radiation oncology centers no longer be able to keep up with new technology?)

No physician fees were included in the analysis, since these fees are addressed separately under the proposed 8 percent reduction in professional fees. ELM staff drew on fifty *pro forma* from previous and ongoing consulting engagements with the express intent of laying out a "typical," but no-frills radiation oncology center that any radiation oncologist or hospital would find appropriate for treatment. The model includes construction and housing of an accelerator, simulator, and basic equipment. Staffing includes a half-time administrative

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director and physicist, a dosimetrist, a supervisor, three technicians, one nurse, two individuals at registration, and secretary/transcriptionists. Annual standard salary increases, benefits, and expenses were included, and a standard mix of complex, intermediate, and simple procedures was assumed. In addition, typical costs of training and education, equipment maintenance, telephone and utilities, insurance, supplies, patient education, marketing, program development expenses, depreciation, interest expense, and loan repayment were computed.

To understand the ongoing impact of the reduction, we assumed that as of Day One the total treatment load of the center was available, i.e., we did not assume any "ramp-up" time. Based on data from a recent American College of Radiology study, we computed net margins, operating margins, adjusted net margins, NPVs (net present values), and IRRs (internal rates of return) for scenarios with seventeen, twenty, twenty-five, thirty, and thirty-five patients a day.

Of course, Medicare does not account for all radiation oncology patient loads. For our purposes, we asked that two sets of numbers be run: one with a Medicare case load at 50 percent of patients; the other with 60 percent. Technical fees, including blocks and treatment devices, were calculated less allowance rates, and net revenues were computed.

## RESULTS

Perhaps the most startling finding was our inability to calculate an internal rate of return for six of the ten scenarios. Computations indicated that the rate was so low that it could not be estimated. In the best case scenario, with an average per day case load of thirty-five patients, the internal rate of return was -5 percent with a net present value of *negative* \$1.5 million at the end of five years. In all other cases, the losses were substantial. At a 50 percent Medicare mix and seventeen patients a day, the radiation oncology center has a negative net margin of \$500,000 in Year One, up to \$830,000 in the Year Five. The NPV on a five-year investment would be (\$5,800,000)—a very bad investment indeed!

In none of the ten scenarios

would an initial investment be recaptured. Essentially, all scenarios are bad investments. Given that many hospitals and other investors have at least minimal positive expectations of return on investment, it is clear from these scenarios that *no new radiation oncology centers will be built*. Moreover, given the increasing levels of Medicare enrollees and these low rates of return, radiation oncology

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centers will not be able to replace or update existing equipment. Even at thirty-five patients a day—not an atypical case load—the marginal rates of return are so low that these centers are unlikely to be able to update equipment.

## THE IMPACT ON RADIATION ONCOLOGY CENTERS

In their article on the structure of radiation oncology practice in the United States, Owen and colleagues found that 22 percent of radiation oncology centers see about seventeen patients per day.<sup>3</sup> From these results, the smaller centers, servicing rural and suburban populations, would likely close quickly. An additional 54 percent of radiation patients are treated on machines that average thirty-five patients per day. Given the out-

come of these analyses, we assume that at least half of these machines would be in jeopardy. Thus, within a few years of enactment of this policy, approximately 50 percent of all U.S. radiation oncology centers would be likely to close for lack of financial viability.

In this case a small sample size, a rapid decision to change directions, and use of an existing database for a secondary purpose have created an unintended consequence. Of course, some might argue that a more efficient system would be pleased to cut in half the number of radiation therapy centers in the United States. HCFA's intent may be twofold: reduce the number of radiation oncology centers and force the surviving centers to operate more "efficiently." This may well entail a dramatic rethinking of care delivery. Certainly, what appears reasonable when dealing with numbers may not be reasonable when considering the consequences to patients and their families.

Making the aggressive assumption that the other half of the radiation oncology centers remained viable (a questionable assumption given that some will also be subject to APCs, which will likely limit their reimbursement), many centers will be forced to cut staffing and run extra shifts to handle the case loads. The upshot will be the need to have patients drive extremely long distances, with a good portion of patients receiving their treatment on a second, or, in some cases, a third shift.

Obviously, this practice is likely to discourage many patients from receiving appropriate therapy and return us to an era of more than a decade ago, when long distances and lack of facilities prohibited many patients from receiving appropriate care. ■

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