Evolution of "Onconomics" from a physician's point of view

— Nash Gabrail, MD, MRCP

Evolution is at the heart of understanding cancer cells. Through mutations, cancer cells gain growth and survival advantages. Oncologists understand and fear mutation and cancer evolution, since this is what causes drug resistance and cancer progression.

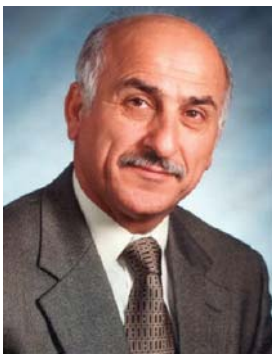
In the past two decades, oncologists have witnessed another evolution that has drastically affected the way we function. We have had to adjust to the market forces that we—and our patients—face in order to acclimatize to the environment and economic realities.

Those of us who have been practicing more than 15 years remember the days when insurance companies (including Medicare) would pay what we billed. There was no RBRVS. We did not need to submit all the diagnostic and procedure codes relevant to the visit. Chemotherapy drugs were reimbursed according to what we believed was fair. We billed and received payment for needles, syringes, port flushes, and other supplies needed to care for patients.

There was no AWP or ASP +/- 6%. Those were the "good old days" for oncology practices, economically speaking. But, professionally, they were the not so good because we had very few chemotherapy and support care drugs. Patients with many types of cancer, such as lung, prostate, kidney, and pancreatic, as well as many other diseases were sent home to die at the time of the diagnosis of their advanced disease. Now we have effective—but very expensive—drugs that help us to treat our patients. These new tools helped to reshape the economic landscape of oncology practices.

The invention of new classes of anti-emetics and growth factors contributed to the inflation of the global health care cost, so much so that policymakers decided to do something about it before the system went broke. These changes are in a constant evolutionary state and are having a drastic impact on the finances of oncology practices—and often on the way oncologists practice.

In the old days, the mark-up of some chemotherapy drugs was 300-400%. In 1995, the *Wall Street Journal* published a front-page article featuring a picture of a mansion whose caption read, "This house was paid for by leucovorin." Oncologists did not have to be diligent in managing their financial spreadsheet. The overhead was barely 50%. A loss of 10% of revenues would not be noticeable. Surveys in the late 1990s showed that, on average, an oncology practice would fail to collect about 8% of what it should. Today with the ASP plus 6%, failure to collect 6% of the allowed amount could translate into bankruptcy.



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Adapting to an ever-changing environment

In order to survive, most oncology practices have adapted to this ever-changing environment. Some are still struggling through the changes. Overall, most practices have managed to stay afloat maintaining their revenue; however, most show a decline in profit. This decline will become more obvious when the full impact of the FDA-mandated change in use of erythropoeitic stimulating agents (ESAs) is realized. What adaptations that have been successfully implemented and what other strategies can be adopted to curb future stringent payment policies? And, what should we expect from payers in the future?

First, office managers are carefully selected and well-paid, talented people. Many of them have MBAs. The same applies to the billing staff. Accurate billing and collection is key. Failure to collect on one dose of Avastin, for instance, would neutralize revenues generated from that drug for several months.

Second, practices need diversification in the services provided by adding imaging and other ancillary services. In some practices, clinical research constitutes a significant portion of the revenues generated. Not many practices are adopting this crucial service because it is cumbersome, time-consuming, and requires a lot of paper work. But, if done right, it can be a better, more cost-effective way to practice medicine, which can also lead to improved profitability.

Third, practices need to optimize their purchasing power for chemotherapy and supportive and palliative care drugs. When the profit margin of those drugs is 6%, at best, a mere 2% savings on the purchase price can translate into a 30% increase in money in the bank. But that cannot be achieved by small practices, since the discounts are volume dependent. This has given impetus to a dramatic increase in the number of large practices with strong purchasing power.

But there are other reasons for the popularity of large practices, such as the affordability and profitability of imaging equipment, in-house pharmacies, and sharing overhead. In theory, that is a good business concept, but has it translated into actual financial gains? While it is difficult to get statistics on the revenues of physicians in small practices compared to large ones, surveys have

shown that revenues per physician actually drop once practice size reaches the medium level (four or more doctors).

Why is bigger not always better?

In simple economics, large corporations are generally less efficient. There is less accountability, because of loose oversight. Physicians in large practices are less conscious about the bottom line since a 10% savings will translate into a 1% gain for the individual physician in a 10-physician group—so why bother? On the other hand, a 10% savings for a solo practitioner is a 10% gain in the bottom line.

Large practices are more likely to add more physicians to the group. Theoretically, that new addition will translate into only a small loss of revenue to the individual physician in the group. Contrast this with a solo practitioner who brings on a new partner who could potentially take half of the revenue in a couple of years. Such aggressive recruitment of physicians may have created a "pseudo-shortage" of oncologists. I call it "pseudo-shortage," because practices are spending time, effort, and money marketing their services. If there is a shortage, why bother to market? A group of 15 oncologists in the Midwest spends $250,000 annually on marketing and public relations. Maybe they should save all that money and effort and instead have 12 oncologists.

Favorable contract negotiation has been one of the cornerstones of large practices. In essence, they attempt to create a market monopoly to force private insurers to submit to a better fee schedule. It has not happened on a large scale yet. Needless to say, a medical monopoly presents an ethical and professional challenge.

Where are we heading? Many experts predict that the revenues of oncologists will decline further, which could change the landscape even more dramatically. Many seasoned oncologists will not find it worthwhile to stay in practice, which could create a manpower crisis.

What should practices do now to keep revenues steady?

Expand based on workload, not with the intention of cornering the market. Just because the revenues are good now, does not mean they will stay that way. The old dogma was to hire more physicians based on the income made by the group. That income is not a constant. It could—and would—decline.

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Mergers of small practices make more business sense than adding new people. Mergers can be a challenge, since there are different practice patterns, individual cultures, and different philosophies. More important, turning competitors into partners and friends is not an easy task, but facing the realities of challenges that practices face should be an incentive for people to set egos and personal differences aside. Local hospitals that see a large group of specialists as a formidable powerhouse may foster some of those differences in an effort to avoid having to deal with them.

Concentrate on ancillary services that are normally provided by the hospitals, such as CT scans, echocardiograms, PET scans, etc. Such services are potentially profitable even for small- and medium-sized practices.

Regardless of the qualities of the managers and the CFOs, physicians have to be intimately involved in the business aspect of the practice. A 5% loss of revenue translates to a 15% loss on the bottom line. Optimizing billing and collections should be the first priority of every practice. The lead physician in the group should work closely with managers to optimize efficiency. Algorithms and pathways are being designed and implemented to optimize revenues. In some practices, the treating oncologists are penalized when they unreasonably deviate from the guidelines.

Staffing management and delegation of responsibility can be a great money-saver. A well-trained medical assistant can handle patients' calls and be paid much less than an RN.

The implementation of electronic medical records (EMR) is probably the most crucial aspect of contemporary practice, especially for those involved in or contemplating clinical research. It is a great tool that provides accuracy in documentation, accountability, and efficiency. Moreover, it is inevitable—sooner or later EMR will become mandatory—and it is affordable. EMRs are a great tool in implementing pathways and algorithms. Many are equipped with capabilities to monitor utilization and compliance with pathways.

What is on the horizon?

Clinical pathways, despite their shortcomings, seem to be the wave of the future. Insurance carriers are pushing for them, and many practices are already implementing them with favorable ratings from the payers, some of which are rewarding the preferential use of generic equivalent drugs. This could become a popular strategy, which might pressure the pharmaceutical industry to lower the cost of drugs.

Sooner or later, payers will either demand EMR or offer incentives to those who have them. Because payers believe it

contributes to providing better medicine and, more important, they can use the data to verify compliance with pathways and algorithms, they will push its adoption. Electronic medical records are becoming popular with sponsors of clinical research and CROs. Soon they will demand it as a prerequisite for site selection.

There is already increasing scrutiny and preauthorization of imaging studies, since payers are increasingly concerned with overutilization of services, especially PET scanners and, to a lesser extent, CAT scans. Similarly, there is ongoing scrutiny on utilization of radiation therapy, especially when dealing with the dose delivered and number of treatments. This has been attributed to physician ownership of radiation therapy units and simulators.

Capitation of chemotherapy in the name of bundling is on the horizon. United Healthcare is already talking about this. Physicians will be paid a set amount for the chemotherapy regimen for a particular disease state. This will force physicians to be selective in favoring less expensive (usually generic) drugs and certainly will influence the use and selection of supportive care drugs. Protocol analyses will shift from what is most profitable to what is most cost-effective. No one should be under the illusion that bundling chemotherapy will be an easy task. Patients differ in their weight, genetic makeup and concomitant illnesses. These are all factors that influence the choice of regimen and dose delivered.

"Outcome" is a buzzword these days. It is a novel idea but hard to implement, especially when dealing with small practices. The insurance industry appears to be pushing for this to neutralize the fear of compromising quality with cost-containing measures. Furthermore, the insurance companies do not want to be perceived as caring only for the bottom line. We have a long way to go before outcomes become a real issue although they should be. It is a cumbersome task.

Medicare has maximized its effort and success in curbing the profit from chemotherapy drugs. Its next step is to lower the professional fees and infusion service reimbursement. Medicare will push for those cuts as long as the vast majority of community oncologists stay in their private practices and as long as oncology organizations continue to fail to resist those changes. Unfortunately, oncologists do not have an abundance of friends in Congress or Medicare. We are partly at fault for this. Medicare and other insurance companies will not rest until the income of oncologists drops to what is equivalent to the average subspecialists. This paints a gloomy picture and poses a real threat to the profession since we do provide a unique, emotionally draining service that requires continuous education to keep up with the rapidly growing knowledge in the field.