Expanding Practice to Provide Integrated Cancer Care

By Dean H. Gesme, MD, and Marian Wiseman, MA

Minnesota Oncology, Minneapolis, MN; Wiseman Communications, Washington, DC

Introduction

Increasingly, specialists involved in cancer care are considering integrating their practices or have already done so. The merging of medical and radiation oncology is probably the most common combination, but other specialists involved in cancer care are also integrating, including urologists, gynecologic oncologists, breast surgeons, and interventional radiologists. In the preparation of this article we learned of medical oncology groups that include internists, pulmonologists, endocrinologists, pain medicine specialists, and psychologists.

Physicians and consultants cite two main reasons for moving from a single-specialty practice to a multispecialty one: It is better for the patients, and it is better for the bottom line. On the patient side, the benefits of integrated care can be summarized by the four C's: It enhances coordination of care, collaboration among physicians, communication among providers, and convenience for the patient. The financial advantages for the practices include improving profit margins, increasing market share, enhancing bargaining power with insurers, and gaining economies of efficiency. Every health care payer wants better coordination and management of care, coupled with cost-effectiveness, so having a coordinated care model can be an advantage when negotiating with health care plans.

Weigh Options, Seize Opportunities

What's involved in forming a multispecialty practice? Could it work for you? Teri Guidi, MBA, the CEO of Philadelphia-based Oncology Management Consulting Group, says that her best advice is to consider it. "Don't rule it out based on a preconceived notion that it could never work." Conversely, Guidi says, "Don't assume it's right for you without exploring further."

Consider opportunities and what makes sense for your practice in your current market. As with any strategic planning, evaluate your strengths and weaknesses. You may need to make changes incrementally. For example, if you have a small medical oncology practice and are thinking of adding radiation oncology, the first step may be to join with another medical oncology practice, thus creating a larger referral base that would enhance your value to radiation oncologists. On average, approximately 50% of patient referrals to radiation oncologists come from medical oncologists, according to Guidi. Some consultants put the number at 70%.

Owen J. Dahl, MBA, a practice management consultant with the Medical Group Management Association (Englewood, CO) describes the incremental process used by physicians he worked with in Louisiana. Initially, three groups, each

of which had three medical oncologists, merged into a single nine-physician practice. "The motivation was fairly simple—become the 800-pound gorilla in the room," Dahl says. Eventually the group grew to 15 medical oncologists and then merged with a gynecology practice and a radiation oncology practice to form a single group with a new tax identification number. The practice originally used hospital-owned equipment but decided as a group to make a capital investment in its own facility and equipment.

"Look for opportunities that will make a difference," advises medical oncologist Lee S. Schwartzberg, MD, of The West Clinic, a multispecialty oncology practice based in Memphis, TN. "Our concept from the beginning was to try to make the clinic a one-stop shop to benefit patients as much as possible." The first step came in 1989 when the practice added a computed tomography (CT) scanner and hired a radiologist. The practice now includes specialists in interventional radiology, pain medicine, gynecologic oncology, endocrinology, and psychology.

"We added oral pharmacy a year ago," Schwartzberg says. "You have to understand your demographic—how much oral drug you are ordering and who is in a managed care plan and can't use the pharmacy—and you have to have a clear-cut formulary."

Vision and Leadership

Both consultants and physician owners state that strong leadership and a steadfast vision are a necessity for developing a multispecialty practice. David Fryfield, MD, a radiation oncologist and the medical director of Willamette Valley Cancer Institute, Eugene, OR, reports that in 1994 to 1995, when his two-physician radiation oncology practice and the group of four medical oncologists across the street first began talking about creating an integrated cancer program, the talks broke down on three occasions. The merger was ultimately successful because Fryfield and one of the medical oncologists "decided we weren't going to let this die. It takes someone with a strong vision who says 'I'm going to make this happen.'" The group moved into its own cancer center in 1997 and now has four radiation oncologists, eight medical oncologists, and four gynecologic oncologists.

Medical oncologist Bimal Patel, MD, also points to a clear, strong vision as essential in addressing the challenges his group faced in expanding their practice. "We were in a large metropolitan area with established imaging and radiation oncology practices. These were colleagues we had worked with over years. But we had faith in the soundness of the model we wanted—

clinically, legally, and logistically.” Rather than merging with an existing practice, his five-physician group built three new centers and purchased two linear accelerators as well as positron emission tomography and CT equipment. The practice, renamed Epic Care, now has eight medical oncologists and leases space to another oncology/hematology group in its 60,000 square-foot main building in Pleasant Hill, CA. The group contracts with a radiology group to provide imaging interpretation, and it recruited two radiation oncologists, who also take patient referrals from outside the practice.

Politics and Personalities

The politics of your medical community must be considered. Schwartzberg says that his group has been careful in the types of services it has added, so as not to compete with or alienate their referral base. For example, although he sees the value of having a multidisciplinary practice with urology, he says that wouldn’t work well in the Memphis area. “The urologists are well organized in large groups here. To partner with one or to hire our own urologist would cause conflicts with the other referring oncologists.”

Reputation is also important. Consider the standing of anyone with whom you might affiliate. “The image in the market is important. If a well-loved group merges with a not-so-well loved group, it can have an effect on external referrals,” Guidi notes.

Address differences in priorities and goals within your practice. For example, are group members most interested in collaboration, patient satisfaction, increased profit margins, or market leverage? Guidi says she asks physicians to name the one thing they can’t tolerate or must have. “Someone might say ‘I want to be in control when I’m in the clinic,’ or ‘I want my nurse by my side all the time.’ You have to address these issues.”

Dahl advises, “Get the staff involved as quickly as possible and have them buy in as soon as possible. The favorite employee of one doctor can kill the whole thing.”

Analyzing the Finances

If you decide to seriously consider expanding your practice to include another specialty, you are well-advised to work with a practice management consultant and financial advisor with experience in oncology practice. As a first step, a consultant will work with you to determine the number of new cancer cases in your market, says Tynan Olechny, a senior consultant with Atlanta-based Gates, Moore, & Company. In further analysis you will need to define the types of cancers that you treat, assess demographic data in your service population, and project the numbers and kinds of new patients you will have in coming years. Industry benchmarks are available to project the services needed by different types of patients.

In projecting revenue, anticipated changes in payer terms must be taken into account. A larger practice, more referrals, and quality control measures may give you more leverage with payers. But payers are also looking at ways to limit reimbursement, says Dawn Holcombe, MBA, president of DGH Con-

sulting in South Windsor, CT. She cautions that public and private payers are starting to limit what imaging can be done, and reimbursement has contracted on the radiation side. “Payers have bundled more procedures and are paying a reduced rate per procedure.”

Capital investment, staffing, and operating expenses must also be carefully analyzed. The initial years of becoming a multispecialty practice are likely to be the most costly, and Dahl advises not to overestimate the benefit of economies of scale derived from merging practices: “It’s not as significant as one would think.” Savings later on are more likely. In an article describing integrating urologists into an oncology practice, Nancy Payne, the executive director of the practice, notes that in the beginning, the business office staff had to learn new billing and accounting procedures.¹ In addition, physician loyalty to office staff led to an agreement that the urologists could keep their staff as long as they wanted. But, Payne writes, over time the urologists realized that they could reduce the number of staff, and economies were gained. Fryefield’s multispecialty practice began with six physicians in 1997 and now has four radiation oncologist, eight medical oncologists, and four gynecologic oncologists. “I don’t think there’s any question that we have economies of efficiency, but it takes a while to get there,” he says.

Compensation: Fairness Is Key

How should the practice income be divided among shareholders? This is unquestionably a tough issue, and one that can prevent some groups from working together. Drs Fryefield, Patel, and Schwartzberg all emphasized that honest talks about perceptions of fairness and value were essential. “The important thing is to reach consensus so each group feels they are getting a fair shake,” says Schwartzberg. Patel puts it this way: “When you create the revenue distribution, you have to make sense out of it for everyone’s hopes and expectations to come.” A physician close to retirement may not be keen to invest in a major practice change. Such variations must be addressed. Guidi reports that some groups have used tiered ownership arrangements or have changed individuals’ status to employees rather than shareholders.

No one compensation model will serve all practices. Some shareholders may choose not to make a capital investment or do a buy-in, and that will affect the distribution of revenue. At Epic Care, after all costs are assigned as appropriate, the net revenue is divided equally among the shareholders on the basis of principles of sharing and contribution to net. The radiation oncologists recruited by the practice began as associates and will become shareholders. Patel comments, “Every group has to find a way to negotiate fairly. It’s a complex issues—will the radiation oncologists have independent referrals, or just treat your patients? Are they just providing services or building a practice. One thing is clear: You can’t expect to hire a radiation oncologist and not pay them the going rate.”

In Fryefield’s group, all of the shareholders receive the same salary. Asked if he questions the fact that practicing as an independent radiation oncologist he could make more money, he

responds, “It doesn’t cross my mind—no. I love practicing with the medical oncologists. We have our oars in the same water and are paddling forward. If you go into it saying, ‘I’m going to make more money,’ it’s not going to work and you’re not going to be satisfied. There’s not enough to hold it together.”

Legal and Reimbursement Hurdles: A Moving Target

Use an experienced health care attorney to help you structure your practice entity and compensation arrangements to ensure compliance with state and federal laws. Notably, unless an exception applies, the Stark Law prohibits physicians from referring patients for Stark-designated health services, including radiation therapy, to a provider with which the physician has an ownership or compensation relationship. Multispecialty group practices that meet certain requirements have an exception to the self-referral prohibition.

Daniel F. Gottlieb, Esq., a partner in the Chicago-based law firm McDermott Will & Emery LLP, works with physician groups to structure compensation arrangements that do not violate the Stark requirements. He reports that the Medical Payment Advisory Commission (MedPac) is preparing recommendations to Congress and the Centers for Medical and Medicaid Services to address a dramatic increase in the volume and cost of radiation therapy and other ancillary services. Two options MedPac is considering would change the Stark regulations, and a third would change Medicare reimbursement.

The first option—prohibition of referrals for radiation therapy within a multispecialty group practice—seems unlikely because so many physician practices are multispecialty groups and such a prohibition would have a dramatic effect on them. Gottlieb adds, “Many of the country’s leading physician groups would be forced to reorganize into separate single-specialty practices or disband.” Two other, more likely options would affect multispecialty oncology practices. One option would require clinical integration in order to qualify for an exemption to the Stark law as a group practice. This approach would favor practices that support a 90% or full-time radiation oncologist. A third option is to adjust Medicare reimbursement rates, perhaps by bundling

services provided during the same patient encounter or episode of care, or by reducing payment for self-referred services. Gottlieb says that MedPac might issue its recommendations by the end of 2010, but the complexity of the issue could delay it until 2011.

Some states have certificate of need (CON) requirements or other laws controlling expansion of physician practices. Which equipment is regulated and which criteria are used to establish need vary by state. For example, 25 states require CON approval for radiation therapy equipment, and 16 require approval for CT scanners.² Some oncology practices have been able to meet the CON requirements in their area.

Expansion and integration of specialties within oncology practice is an increasingly popular strategy that can provide patient convenience and continuity while offering the practice a diversity of revenue streams. It is a complex strategy with many risks and benefits and calls for careful assessment and thorough due diligence. Only you can determine if it is right for you and the future of your practice.

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Author Contributions

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Data analysis and interpretation: Marian Wiseman

Manuscript writing: Dean H. Gesme, Marian Wiseman

Final approval of manuscript: Dean H. Gesme, Marian Wiseman

Corresponding author: Marian Wiseman, MA, Wiseman Communications, 213 8th St NE, Washington, DC 20002; e-mail: marian.wiseman@earthlink.net.

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