

# compliance

## Staffing Based on RVUs— The Times Are Changing

**T**he Golden Rule of Data is: He Who Has the Data Rules! Depending on the data your cancer program captures and analyzes, you can use the resulting information for practice management, risk management, revenue enhancement, contract negotiations, and/or practice efficiency. In today's economic environment, every cancer program should be able to produce, monitor, and benchmark basic metrics to meet current business pressures for increased efficiency and efficacy of care.<sup>1</sup>

In addition, many cancer programs find themselves in an ongoing battle to support the number of full-time equivalent employees (FTEs) required to provide services in the hospital department or freestanding cancer center. In many facilities, annualized relative value units (RVUs) are used to determine the necessary staff allocation, but with the current increase in the number of packaged services, bundled codes, and case-rate payments, cancer programs may want to consider another method to justify staffing needs.

Non-healthcare industries have long recognized the vital importance of productivity measurement for the success of a business enterprise. The basic definition of productivity is measuring the work output per individual worker, and for healthcare this is measuring clinical productivity. In the automobile industry increased worker productivity results in the ability to build a higher number of cars with a fixed workforce. In any industry where productivity measures directly impact a worker's salary, the worker becomes more motivated to produce. Productivity

measurements in healthcare tend to be more subjective, such as "everyone knows" that Dr. A is efficient and Dr. B tends to dawdle between patient encounters.

So, what is the correct number of physicians and support staff needed to meet the requirements of the cancer program? There may not be a single answer to this complex question.

### What is an RVU?

The *Current Procedure Terminology (CPT®)* Manual codifies procedures and is updated annually by the American Medical Association (AMA). Prior to 1992, Medicare reimbursed physicians for their services based upon the charge billed for the code submitted. In 1992 the federal government attempted to standardize physician payments and established the resource-based relative value scale (RBRVS). The RBRVS assigns a complicated numerical value to every CPT code, referred to as the relative value unit (RVU).

It is important to note that there is significant physician involvement in setting the RVU value for each procedure code. The AMA Specialty RVS (relative value system) Update Committee (RUC) provides ongoing recommendations for annual updates to physician RVUs. There are currently three components that comprise the RVU: physician work, practice expense, and professional liability insurance (PLI). The work component includes such items as time, mental effort and judgment, technical skill, physical effort, and the stress involved in delivering the care. The practice expense (PE) component includes overhead and other

expenses required to maintain the facility. In the outpatient department of the hospital, the hospital is reimbursed for the practice expense of the service or procedure under the Medicare Outpatient Hospital Prospective Payment System (OPPS). Last, PLI is the cost and value of malpractice insurance.

Each of these three components is then adjusted by the geographic practice cost index (GPCI), to correct variances in the cost of living for different regions of the country. The total RVU amount is then multiplied by a conversion factor (CF), which is updated annually, to determine the fee schedule dollar amount.

Easy, right? The bottom line, of course, is that physician compensation from Medicare (and other payers that use RVUs) is derived from the RVUs assigned to a specific procedure code. And of course the RUC is a privately-run regulatory committee that must maintain budget neutrality when modifying RVUs on an annual basis. Budget neutrality means that if the relative value is increased for one procedure, the increased amount must be taken from other existing procedures.

### RVUs & Staffing

Staffing is generally driven by demand: how many and what types of patients will the cancer program expect to see in the upcoming year? Demand can then be converted to work: the specific tasks that must be performed in order to treat these patients, including that work considered to be indirect patient care.

Staffing plans address the facility's mission, structure, workforce, recruitment,

needs of the cancer program, and retention to meet current and projected patient outcomes, clinical effectiveness, and efficiency. Staffing plans should also consider performance measures, patient outcomes, and other indicators of accessibility and quality of care.

Projecting patient demand includes an analysis of historical patient utilization and determination and assessment of change factors that will affect future demand. Make certain to consider trends that could increase or decrease the number of patients that require treatment at the cancer program, such as:

- **Population trends.** Is the community growing or aging, are there new residents, or is there a migration away from this community?
- **Local healthcare factors.** Will a hospital or freestanding cancer center in the region be closing, increasing, or changing its cancer treatment offerings, or will there be more uninsured or underinsured patients?
- **Changing referral patterns.** Do you anticipate more or less referrals from community physicians and are these referring groups increasing or decreasing in size? Are any current referring physicians planning to initiate cancer treatment? Are physicians other than oncologists offering cancer treatments?
- **Facility-specific factors.** Will your cancer program have new technology or new offerings next year? Is your cancer program accredited? Will your cancer program offer clinical trials?

- **Best practices.** Are treatment protocols, pathways, and best practices that are under review anticipated to change in the near future? Are changes anticipated during the next five years?

“The National Practice Benchmark for Oncology, 2013 Report on 2012 Data” is a tool to measure oncology practices against others in the country in a way that allows for meaningful comparisons.<sup>1</sup> According to this report:

*In the past, we reported HemOnc [hematology/oncology] physician productivity based on the number of new patients per year. We now report HemOnc physician productivity on the basis of work relative value units (wRVU) and use 7,000 wRVU per year as the productive capacity of a standard HemOnc physician (wRVU). When used in the aggregate,*

*there are often only slight differences between the results expressed per FTE HemOnc or per standard HemOnc (wRVU). This is reasonable because these two measures are derived from the same aggregated data in which the number of new patients and the amount of wRVU are strongly correlated. When applying any individual benchmark to an individual practice, we encourage the conversion of the FTE HemOnc count for the practice to standard HemOnc (wRVU) and suggest using that as the standard of comparison. This provides useful comparisons both for busy practices and for those that are less busy.*

For the first time, this report included radiation oncology benchmarks and tentatively introduced a new standard for the productive capacity of a radiation oncologist. The report defines a standard RadOnc



physician as one with 26 average daily treatments (on the basis of 254 working days per year). In addition, the average number of new radiation oncology patients per FTE RadOnc was listed between 250 and 300 patients. This report also states:<sup>1</sup>

*We also measured wRVU per RadOnc physician and see an average of around 14,900 wRVU per RadOnc per year. There is, however, considerable variability in that number, which we believe reflects the ratio of complex treatments to total treatments, and we are not yet prepared to establish a standard RadOnc on the basis of wRVU.*

## RVUs & Physician Compensation

In some cancer programs, the physicians may receive equal compensation. In other programs, the physicians may receive an annual salary with a productivity bonus. Other compensation models may tie salary to the RVUs generated by each physician. In fact, RVU productivity is the most common form of quantitative metrics used to determine physician pay today, with “work” the behavior that is measured and rewarded.

According to a Medical Group Management Association (MGMA) 2007 survey, 61 percent of physicians were compensated based on RVU production.<sup>2</sup> A 2011 Merritt Hawkins (physician recruitment firm) white paper showed that salary plus a production bonus was the compensation formula offered to physician candidates in a third of physician search assignments.<sup>3</sup> Of importance is the fact that in most cases the productivity measurement was not based on quality of care, patient volume, a cost effectiveness metric, or revenue generated.

Arguments in favor of compensating physicians based on RVUs include objectivity, removal of distinctions between payer types, and not rewarding inefficient care. Arguments against this application of RVUs include intra-group competition for complex cases or those that have high RVUs, creation of RVUs by “slow” physicians through repetition of procedures, and not referring patients to

other physicians in order to keep the RVUs in house. In addition, participation and contributions to the group or facility’s overall strategic plan is not a factor in RVU bonus models.

The employment of non-physician practitioners (nurse practitioners, physician assistants) alters the RVU compensation or bonus system significantly. Each non-physician practitioner is supervised by a physician, but the RVUs for the services performed are allocated to the non-physician practitioner.

## Concerns with Using RVUs

The biggest problem with tying physician compensation or staffing to RVUs is that when these relative values change, and some of these changes are significant, the model may not be sustainable. As proposed by the Centers for Medicare & Medicaid Services (CMS), radiation oncologist reimbursement is estimated to decrease by 4 percent in calendar year 2015 and payments to freestanding radiation oncology centers is expected to decrease by 8 percent. Does this mean that physician compensation or staffing levels should decrease accordingly because this monetary loss is due to a decrease in RVUs?

A standard approach when cost reduction is necessary requires reducing the payment amount for each service. With the exception of the sequestration reductions, CMS typically reduces the value for some procedures while increasing the value for other services on a year-by-year basis. This means that the RVUs for a particular service may decrease from one calendar year to the next due to budget neutrality, changes in practice expense allocations, etc. For example, at the time this article was written CMS had proposed to reduce payment for all treatment delivery services in a freestanding radiation center because the cost of the radiation vault would be removed from RVU calculation as a direct practice expense. If staffing is performed based on RVUs and the RVUs are significantly decreased while the cancer program has no change in costs,

staff may be decreased inappropriately. Other issues to be considered when staffing based on RVUs include:

- **Bundled services.** CMS publishes its bundling guidelines, which indicate that certain codes cannot be charged on the same day by the same provider as other services. For example, a simulation (codes **77280-77290**) cannot be charged on the same day as a 3D computer plan (**77295**) for Medicare. If RVUs are only tracked for billed services (the 3D plan), there is no credit received for the bundled procedures that required physician and staff time. With respect to medical oncology, there are services such as venipuncture, nursing time, or patient chair time for infusions that may not have RVUs but contribute to patient care. Last, bundling edits are updated quarterly, so bundled services can change during the course of the calendar year.
- **Medically unlikely edits.** At present, the most common oncology medically unlikely edit (MUE) occurs with basic dosimetry calculations (code **77300**). Medicare contractors typically have a maximum unit allowance that will be reimbursed, although all units will be paid when medical record documentation is provided after the line item is rejected. How will RVUs be tracked in this scenario? Only those units initially paid or all units after appeal?
- **Packaged services.** In general, the packaging of services occurs in the outpatient department of the hospital. For example, the hospital bills for image guidance during daily radiation treatment delivery and fiducial marker placement, but this service is not separately paid. Instead, it is considered packaged into the reimbursement for the primary service (treatment delivery). And, with the advent of comprehensive APCs (C-APCs), CMS intends to package all services performed on a single service date for a number of outpatient procedures, which will expand the impact of this concern.

Exclusive use of RVU generation systems to determine staffing, distribute profit after expenses, or compensate physicians also fails to reward other behavior that is beneficial to the group or facility. Examples include:

- Willingness to take patient calls
- Regular participation in group or medical staff meetings
- Tumor board participation
- Performance of outreach services
- Achievement of quality assurance goals
- A history of positive patient and staff interaction
- Principal investigator responsibilities related to clinical trials.

Just because there is a concern with an RVU staffing or compensation system doesn't mean that there is a perfect alternate solution. In addition to billable RVUs, there are other ways to measure clinical productivity and staffing needs. The number of patient visits or the number of new patient encounters can be easily measured, but do not reflect actual collections. Gross charges are also easy to calculate, but do not reflect contractual adjustments or discounts. Charges adjusted for insurance contracts are also easy to produce, but are based on uncollected charges and do not allow for payer mix variations. Net collections reflect actual collections, but may discourage physicians from providing care to uninsured or under-insured patients.

### Shifting Reimbursement Focus

According to information published in the *MGMA Connexion* July 2013, preparing for reimbursement models that place a greater share of financial risk on the provider is one of the top ten healthcare industry challenges. One of the greatest healthcare challenges of the next few years is getting control of the skyrocketing costs of treating cancer. The U.S. spends as much as \$127 billion on cancer care in a year, and that is projected to grow to at least \$158 billion by the end of this decade.<sup>4</sup> According to an article in the *Journal of Oncology Practice*:<sup>5</sup>

*The cost of healthcare in the United States*

*is on an unsustainable trajectory. Using current trends, economists predict that in less than 3 years, it will require 50% of the average U.S. household income to pay the costs of out-of-pocket expenses and the health insurance premium for a family.*

*New payment models that reward cost-effective and high-quality treatment are needed.*

In a separate article, the American Society of Clinical Oncology (ASCO) states:<sup>6</sup>

*Although 1.5% of patients develop cancer in any given year, they account for roughly 10% of all health care costs. Of the top 10 drugs that Medicare pays for as part of a beneficiary's medical benefit (the so-called Part B drugs), eight are used in the treatment or supportive care of patients with cancer. Pursuing aggressive control of expenditures, Medicare and private health insurers have increased their focus on high-cost areas, including oncology.*

*Oncology is a special focus because of the patient complexity, the life-threatening nature of these diseases, and headline-grabbing prices of therapies.*

Medicare is accelerating plans to commit a portion of physician pay to the quality of care provided. The current payment system (fee-for-service) financially encourages physicians to perform or order more procedures and may be one of the reasons healthcare costs have escalated. The Affordable Care Act (ACA) requires Medicare to gradually factor quality into payments for hospitals, nursing homes, physicians, and other medical providers.

By 2017, the value-based modifier program will include all physicians, who stand to gain or lose one to two percent of their pay based on quality measures that vary from one specialty to another. In addition, Medicare plans to take into account how much each physician's average patient costs Medicare, to encourage more judicious use of testing and more aggressive efforts to avoid hospitalizations. Physicians will be compared against others in their specialty and those with least costly patients will be eligible for larger bonuses.

Cigna has met its goal of covering 1 million healthcare consumers under its quality and performance-based model called Cigna Collaborative Care (CCC) Arrangements.<sup>7</sup> This program was previously called Collaborative Accountable Care and works with healthcare professionals across the delivery spectrum that have a substantial primary care component. Regardless of practice type, the common thread is that the medical group must be willing to accept responsibility and accountability for achieving improved health, affordability, and patient experience. In this model, the medical group is rewarded through a pay-for-value structure if it meets targets for improving quality and lowering medical costs.

And Cigna is not alone; in 2014 United-Healthcare (UHC) announced that \$27 billion of its annual reimbursements to physicians and hospitals are tied to accountable care and performance-based programs. By 2018, UHC is hoping to increase that to \$65 billion. More payers are moving to risk-sharing arrangements, and they are being aggressive about strategy.

According to the *Wall Street Journal*, Americans spent \$37 billion on cancer drugs in calendar year 2013, more than for any other ailment.<sup>8</sup>

"Oncologist reimbursement at the moment is a broken system," Richard Schilsky, ASCO's chief medical officer, told the newspaper.

Effective July 1, 2014, WellPoint initiated a program in six states to offer oncologists monthly payments of \$350 for each patient treated in compliance with one of the insurer's recommended treatment pathways. The program's initial focus is on breast, lung, and colorectal cancers first and is expected to encompass the complete WellPoint network by mid-2015. The intent is to treat cancer using protocols that are supposed to be more cost effective and offer the right amount of benefits versus side effects.

While some physicians expressed concern about standardized treatment, WellPoint

expects that its treatment protocols, developed with guidance from oncology groups and outside experts and reviewed quarterly, will apply to approximately 80 to 90 percent of patients receiving chemotherapy. In addition, there are no penalties for using other treatments.

According to the WellPoint Cancer Care Quality Program Provider FAQs<sup>9</sup>, the program will be administered by AIM Specialty Health®, a separate company. Two existing HCPCS Level II codes will be reported to obtain the enhanced reimbursement:

- **S0353:** Treatment planning and care coordination management for cancer, initial treatment
- **S0354:** Treatment planning and care coordination management for cancer, established patient.

According to the claim filing instructions, once a cancer treatment pathway regimen is selected through the program, WellPoint can be charged once for code **S0353** at the onset of treatment. Code **S0354** will then be billed no more than once a month (e.g., no more than once each 30 days of treatment) up to the maximum number of months specified by the prior approval process and program instructions.

"It's clear that our approach to cancer therapy is the answer in making a positive impact on quality and in slowing the rate of these increases to keep premiums as affordable as possible," Doug Weners, WellPoint senior vice-president for provider engagement and contracting, said in a news release about the program.<sup>10</sup>

Of particular interest to medical oncology practices, UnitedHealthcare experimented by paying participating physicians a monthly allowance to cover the full course of treatment, rather than reimbursing for each individual service.<sup>11</sup> For the five oncology groups in the study, medical costs for 810 patients with lung, breast, and colon cancer were \$65 million, versus \$98 million for similar patients whose doctors received standard payments. With a savings of \$33 million,

cancer costs were lowered by one third and hospital stays were significantly reduced.

### Oncology Medical Homes & ACOs

Other new payment models may include patient-centered medical homes and, specifically, oncology medical homes. In a medical home, each patient is managed by a physician-led care team and the practice becomes the central coordinator of care throughout all phases of treatment. This includes surgery, radiation therapy, chemotherapy, and survivorship, with communication between the oncology team and the patient's primary care team to ensure that all non-oncologic conditions are also managed. A June 13, 2011, article in *Oncology*, states, in part:<sup>12</sup>

*In summary, the oncology medical home has the potential to be a holistic solution to improving cancer care delivery. Instead of attempting to provide individual solutions to the problems of quality, outcome measurement, avoidance of ER visits and hospitalizations, and improve care coordination, the oncology medical home can create both the structure and process to address these issues simultaneously. Furthermore, it places the responsibility for and authority over cancer care delivery where it belongs: in the hands of those who are actually accountable for the delivery of cancer care—the medical oncologists.*

Accountable care organizations (ACOs) are being established in many areas. If the goal is for physicians to play a major role in reducing the cost of healthcare in the U.S., compensation models for physicians must also be aligned with incentives for ACOs. An ACO is defined as a healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients.

Increased linkage between physician compensation and value-based metrics appears inevitable, but the long-term

consequences are subject to debate.<sup>13</sup> Excluding physicians in ACOs and patient-centered medical homes, specialists polled for the 2013 MGMA survey said about 5.7 percent of their total compensation was based on quality metrics, up from 2 percent in 2012. Healthcare payers will directly influence payment for oncology services as value-based metrics become tied to reimbursement.

Future value-based payments may be similar to capitation models of the past, but where capitation typically involved individual physicians negotiating separate deals, pay-for-value means all providers are participating in the program together. This emerging landscape of population health management includes a movement toward risk-based reimbursement.

### New Staffing Models

As indicated above, there is no perfect staffing or physician compensation model, but healthcare in general and oncology in particular is rapidly outgrowing an RVU compensation and/or staffing model. According to Max Reiboldt, president and CEO of the Coker Group:<sup>14</sup>

*We are seeing a fair amount of handwringing in terms of these deals. We are changing the paradigm of how doctors are being paid. It's not 100% (relative value unit) productivity anymore.*

Rather than a pure productivity model (individual physician collections or RVUs), a salary plus productivity bonus model may be considered. Here is an example of a hybrid or composite model that incorporates several aspects of patient care:

1. **Set on-site schedule.** Whether it is 4 ten-hour days, 5 days per week, or another set schedule.
2. **New patient encounters.** The physicians have an agreed-upon schedule for new patients, including time from contact to first visit. There is also credit for inpatient hospital consultations and other off-campus or out-of-the-office patient contact.



**Table 1. Staffing per Number of New Patients Annually, 8 hours per Day, 5 Days per Week**

Radiation oncologists	1 per 200–300	Clerical staff	At least 1 per 200
Medical physicists	1 per 200–300*	Treatment aides	As needed
Dosimetrists	1 per 300–350*	Maintenance & service staff	1 per 3–4 MV, VT, PET/CT, MRI units
Nurses	1 per 200–300	Dietitians	As needed
Radiation therapists	1 per 100–150*	Physical or rehabilitation specialists	As needed
Simulation staff	1 per 200–250	Social workers	As needed
Brachytherapy staff	As needed		

\* = 25% IMRT

**3. Downstream revenue.** The physicians receive credit for patient care provided by other specialties or departments in the organization.

**4. Outreach.** Physicians are expected to participate in the cancer program's outreach activities to individuals who are not likely to access treatment independently.

According to an article in the *Journal of Oncology Practice*:<sup>15</sup>

*We believe that the FTE HemOnc is the rate-limiting resource in oncology practice. That is to say, when the work output of the HemOnc goes up, all the other supporting assets of the practice are made more efficient because they are predominantly fixed costs. With that in mind, patient visits per FTE HemOnc is a reasonable proxy for overall practice efficiency.*

*Patient visits drive the demand for clinical support staff.*

The National Practice Benchmark for Oncology adds:<sup>1</sup>

*New patient volume continues to be an*

*important measure of productivity and an essential tool for practice planning. A new patient is defined as one that has not received services in the practice in the last 3 years.*

The American College of Radiation Oncology (ACRO) *Manual for ACRO Accreditation, July 2013* includes practice demographics that “will be examined to help define the nature of the patients treated and the services offered.” The number of these services may also be helpful to an individual practice when staffing levels are being determined:<sup>16</sup>

- Number of consultations (visits)
- Number of new patients treated
- Number of patients re-treated
- Number of patients treated with curative intent, palliative intent, and for local tumor control
- Number of simulations
- Number of external beam treatments (IMRT, SRS, SBRT, electrons, and standard EBRT)
- Number of brachytherapy procedures
- Types of special procedures
- Anatomic sites and stages.


ACRO also provides general staffing recommendations as part of their *Accreditation Manual* (see Table 1, above).

These staffing numbers are similar to those listed in *Safety is No Accident*, sponsored by the American Society for Radiation Oncology (ASTRO)<sup>17</sup> and developed and endorsed by most radiation oncology colleges, boards, and societies. Key differences surround medical dosimetry (this reference supports 1 per 250 patients treated annually) and radiation therapists (1 per 90 patients treated annually).<sup>17</sup> ASTRO also puts a number to brachytherapy technologists (1 per 100 brachytherapy patients) and both references clearly state that there should be a minimum of 2 qualified individuals (e.g., therapists) present for radiation treatment delivery.<sup>17</sup>

The ASTRO publication provides sample worksheets for calculating medical physics and dosimetry staffing that includes equipment, sources, systems, number of patient procedures, and nonclinical estimated effort.

## A Look Ahead

It can be frustrating to attempt to justify staffing levels based on flawed data, but this frustration cannot be used as justification for incorrect coding in an attempt to support maintaining staff. It is also clear that healthcare reimbursement will not continue to increase at historical rates. With operating margins decreasing and reimbursement dropping, cancer programs need a well-educated administrator and a forward-thinking reimbursement and staffing plan. In addition, physician groups or facilities that currently compensate or staff based on RVUs may want to transfer the coding function to a certified coding professional to ensure accuracy and remove the potential coding bias that may be present in an RVU-based compensation system. Last, but certainly not least, it is important to conduct regular coding and billing audits to ensure that the charges billed and paid are correctly documented in the individual patient's medical record.

Determining the right level of staffing is important because it can positively or negatively affect the cancer program. Understaffing can lead to physician burn-out and adversely affect physician and staff performance. Overstaffing can affect the program's financial performance and the credibility. At the end of the day a physician practice or cancer program, in order to survive, has to have more money coming in than going out, regardless of how many or how few RVUs are generated. 

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