What Is Proper Cancer Care in the Era of Managed Care?

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Managed care and proper cancer care need not be mutually exclusive entities. Managed-care organizations (MCOs) that are committed to patients and society should have the following characteristics: accountability for

Introduction

Only 20 years ago, about 6 million people were enrolled in health maintenance organizations (HMOs). Today, 20% of the population (over 58 million people) are enrolled in HMOs, and about 45% (152 million) have health-care plans that have some of the essential features of an HMO.[1]

Descriptions of the various types of managed-care organizations (MCOs) can be found in the glossary.

Clearly, there is more to managed care than cutting costs.[2-4] The essential characteristics (gold standard) of managed care are[2]:

- Accountability for results
- Cost containment
- Measurement of health-care outcomes
- Health promotion and disease prevention programs
- Resource consumption management
- Emphasis on primary care
- Continuous quality improvement

These features provide the foundation that supports "proper" cancer care.

Managed Care: Perceptions and Realities

The MCO at its best would conform to the blueprint set forth above. An informal telephone inquiry of a cross-section of the MCOs that are clients of the Medical Care Ombudsman Program of the Medical Care Management Corporation in Bethesda, Maryland, revealed good intentions and processes to follow through on those intentions.

For example, the better MCOs are striving to attain the goals set forth in that blueprint and want to know when they are perceived as failing to do so and what they can do to improve. These MCOs routinely seek help in setting up a treatment plan for difficult cases at the earliest stages of diagnosis. They also quickly refer patients out when the best level of care is available elsewhere, even when elsewhere is across the country. The MCOs contacted (1) are concerned that fully informed consent is obtained from patients, (2) shared the results of outside review of their medical records, (3) directed patients to centers of excellence and to meaningful clinical trials, when available, and (4) were open to exploring other therapeutic options when patients were ineligible for the treatment plan being proposed for their care.

A similarly informal telephone survey was conducted among cancer patients who had utilized the Medical Care Ombudsman Program volunteer program to help solve problems related to issues with their MCO. This survey elicited the following typical problems:

- Wrong frequency of needed follow-up tests
- Refusal to refer the patient when the needed diagnostic equipment was not available within the program
- Refusal to provide psychosocial care or refer the patient out for such care
- Reluctance to provide care internally for late effects of cancer treatment and refusal to refer externally to specialists for such care
- Genetic discrimination; ie, when tests disclose a genetic link to disease, either do not disclose
the information or do not effectively manage, counsel, and provide psychological interventions as needed

- Propose the cheapest intervention and fail to disclose other options even when they would likely be more effective for the individual patient than the option disclosed
- Lack oncologists with training in the intervention sought
- Practice skimming; ie, make the MCO "user-unfriendly" to persons with disabilities and serious illnesses so that the intelligent shopper with those problems will find the plan unpalatable. Several instances of this practice were verified.

Proper Oncology Care

The Gold Standard
Ideally, the care of cancer involves a partnership among the patient, family or significant others, and oncology care team.[5,6] Oncologists view themselves as the patient's ally and advocate. Traditionally, the oncologist and patient have drawn the road map for the patient's care. This road map has provided access through oncology specialists to appropriate screening, diagnostic tests, standard and new treatments, and, increasingly, participation in well-designed clinical trials.[5,6] Referral for participation in meaningful clinical trials is considered the standard of care when patients have exhausted proven treatment options or when those options are inappropriate.[7,8]

Realities and Challenges Under Managed Care
Left to its own devices, managed care may take the development of the treatment road map largely out of the hands of the patient/oncologist partnership in favor of a one-size-fits-all system of cancer care. The oncology community must take a proactive stance to affirm the right to develop cancer care management systems that retain sufficient flexibility to accommodate individual patient requirements and foster the seamless integration of care. To attain this seamless integration in the managed-care era, the oncology community must change with the times, throw off the impediments of inefficient, unnecessary care, and become partners with MCOs in the delivery of proper cancer care. Oncologists must be willing to become the community's conscience to ensure that MCOs provide proper cancer care. How oncologists meet this challenge will depend on their level of commitment and the resources that each participant--medicine, managed care, and consumer--is willing to expend.

Finding Common Ground

Essential Responsibilities of the MCO
An ideal cancer management program within an MCO includes activities designed to help enrollees avoid cancer; to promote early detection of cancer; to furnish the best treatment and follow-up (over both the short-term [for recurrences] and long term [for secondary cancers]) of cancer patients and survivors; and to monitor for late effects. The MCO's efforts in these areas should target enrollees in their communities, at home, and in the workplace. Environmental hazards specific to a particular community should factor into MCO planning, as should how to provide and handle genetic testing and its ramifications for the enrollee and family. The MCO assumes the responsibility for helping the enrollee lead a healthy, productive life. Managed care can do a much better job of promoting wellness and prevention and early detection of cancer than can traditional fee-for-service medicine. These goals can be achieved by offering regular, periodic communications; providing health education to encourage wellness and prevention (eg, eating a healthy diet, getting an annual mammogram), including information carried on the Internet; and offering such preventive interventions as smoking cessation and exercise programs.
In many plans, especially "gatekeeper" plans, the primary-care physician is the initial point of contact, although open-access plans (where a patient can go directly to a specialist) are becoming very popular. In both types of plans, practice policies should establish what should be done for a particular patient and when to refer that patient. Quality assurance and quality improvement programs should ensure that the right practice policies have been implemented and that these policies are being followed. This approach should reduce such problems as misdiagnosis of cases, failure to refer, and so on.
Compared with traditional fee-for-service medicine, MCOs can provide the alert consumer and worried-well with better access to medical advice and also can manage demand for care more cost-effectively. The ask-a-nurse and other demand management programs are examples of approaches that have proved successful in this regard.
Through health education (to motivate patients to seek care and advice), and by providing greater access to screening and other preventive interventions, MCOs should be able to detect and treat patients with cancer at earlier stages--a strategy long held to improve the chances of survival. Through the adoption of policies that embody the best medical practices, MCOs should contribute to improvements in treatment. These policies should cover who should treat the patient, and where, how, and when that treatment should be provided.

Managed-care organizations can coordinate care, ensure proper follow-up, and help patients enhance their quality of life. The fact that MCOs are responsible for patients' continued care should eliminate the problem cancer survivors have had in finding affordable health insurance.

Managed-care organizations should also educate employers about how to deal with cancer survivors, eg, if that is necessary to promote the patient's rehabilitation.

**How the Oncology Community Can Enhance the MCO Model**

The activities described above constitute a well-rounded program to address cancer issues within an MCO. The oncology community's opportunities to shape the way an MCO fulfills its mandate vary from community to community. What cannot vary is the commitment of oncologists to do whatever is needed to achieve ideal cancer care in their community. Furthermore, they must take concrete steps to communicate to the MCOs their readiness and willingness to help in these endeavors.

Managed-care organizations have every incentive to use specialists if it can be shown that the care provided by specialists is the most cost-effective. Managed-care companies also have incentives to ensure that specialists follow established practice policies and practice efficiently. Given the same demonstrated patient outcomes, plans will naturally contract with providers who can offer lower cost and greater patient satisfaction (eg, more convenient locations and office hours, friendlier staff).

Responsibility for follow-up, again, naturally depends on the cost-effectiveness of primary-care physicians vs specialists.

Disease-specific groups that are heavily involved in prevention and education, such as the American Cancer Society, could consider offering stepwise educational programs to prepare MCO members of all ages to be informed consumers of medical care--particularly cancer care--and to avoid health and cancer risks.

Cancer survivors, particularly survivors of childhood cancer, require special follow-up. The oncology community must make MCOs aware of the need to provide surveillance of cancer survivors as part of their follow-up obligations to their enrollees.[9,10] The oncology community should provide ongoing education and support to the MCO to devise and implement protocols for the follow-up of long-term survivors of cancer.

**Opportunities for the Oncology Community**

Quality assurance and quality improvement provide special opportunities for the oncology community to effect proper cancer care in the era of managed care, especially in relation to the introduction of new treatments through clinical trials.

**Quality Management**

Managed-care organizations have the resources to ensure compliance with practice policies known or assumed to produce optimal patient outcomes, to measure care processes and patient outcomes, and to change practice policies, if indicated by those data, in order to produce improvements in patients' health status at lower cost.

While MCOs need to--and theoretically can--follow responsible, quality guidance from medical community, patient advocacy groups, and others, the key issues are, will they follow such guidance, and how well will they do so? Society must provide MCOs with the proper incentives to implement meaningful quality management systems and institute mechanisms to ensure that they do so. Managed care requires mechanisms for quality improvement to close the gap between what should be done and what is being done.[11] Inevitably, quality assurance and quality improvement will entail monitoring of providers' performance and accountability for results.
Recent actions taken against HMOs that have refused appropriate referrals or treatments provide an additional incentive for MCOs to have processes in place that will avoid foreseeable liability exposures by ensuring that patients get the treatments that they need when they need them and that there are no "gag" rules at the core of their cost-control process. In their role as "community conscience," oncologists should monitor quality management within their local MCOs and act constructively to identify deficits and lend a hand to correct them.

Patient Participation in Clinical Trials
Traditionally, insurers have not covered experimental or investigational treatments, nor have they paid for patients' medical care costs to participate in clinical trials.[7-8,12] So why should MCOs? Patients will continue to demand access to new treatments for life-threatening illnesses, especially if the proponents of these treatments say that they offer a chance for cure. Managed-care organizations will resist paying for experimental treatments to contain costs, and they should do so until there is substantial evidence that those treatments are effective (value for money). The exception to this would be if the MCO has a process in place that includes participation in meaningful clinical trials at the plan level or through referral (value through expansion of clinical knowledge, which may translate into value for money).[11,13]

Measurement of patient outcomes is a core value of managed care. Managed-care organizations can measure and improve patient outcomes without clinical trials. However, to improve knowledge--and hence quality of care--MCOs must facilitate patient participation in meaningful clinical trials. The Medical Care Ombudman Program's managed care, indemnity, and self-insured employer clients have all expressed the fear that paying for participation in clinical trials as an acknowledged benefit may place them in a compromising situation. Does coverage of participation in a scientifically sound clinical trial (eg, one sponsored by the National Cancer Institute or a cooperative group) compel coverage of any treatment that wears the label "clinical trial?" A proliferation of institutional treatment plans called "clinical trials" offer off-trial access to treatments under study, thereby undermining the successful completion of meaningful trials (and the cost-containment and quality-assurance efforts of MCOs).[14]

Thus, before endorsing participation in clinical trials, MCOs require some safeguards on the appropriate expenditure of funds. Some of the Medical Care Ombudman Program's clients ask the program's academic medical reviewer panels to assess clinical trials' scientific adequacy and to determine whether a patient who wants to participate in a trial meets the study criteria. The oncology community must be willing to take on the challenge of identifying pilot studies and trials that are needed and valuable and providing that information to MCOs.

To satisfy advocates' demand for access to new treatments, the FDA made it possible for any cancer treatment that appears reasonably safe to obtain an IND. Although this strategy may improve patients' access to new treatments, it devalues the IND as an indicator that the trial is scientifically rigorous and that the underlying treatment has a rational basis. The federal government has not responded to payors' requests to place its imprimatur on meaningful trials and pilot studies. Such an action would facilitate coverage for scientifically valid trials while insulating payors against litigation demanding payment for unnecessary or unsound trials. However, it may also further facilitate medical care.

Society, through patient advocacy and political pressure, has broadened patient access to treatments. A similar effort is needed to open the door to appropriate coverage.[5,6,15,16] In this way, the notion of value for money, which is implicit in managed care, will be served. The patient with cancer will have access--through enrollment in a clinical trial or, when appropriate, through compassionate relief--to an experimental or investigational treatment that may not be life-extending or -saving but will certainly contribute to medical knowledge and lead to improved treatments. Society may not find this crusade for value for money as palatable as that for broader access because it involves difficult choices. It restricts choices, providing access to standard therapies that are known to improve health outcome in certain profiles of patients and permitting access to "new" or, hopefully, "improved" treatments only through participation in meaningful clinical trials, with some provision for rational compassionate use. This approach develops and expands knowledge and encourages choices beyond standard therapy because it encourages patients to participate in clinical trials.

Under this scenario, if patients want to receive a "new" therapy that has not been proven effective and they are eligible for a trial, they certainly will find someone who is willing to provide that therapy without trial participation. However, they will not have access to MCO resources to pay for it; rather, the patients will have to foot the bill. Thus, MCOs could--and should--supplement government and philanthropic funding for clinical trials by paying for the medical care costs of those participating in
them. This approach suggests that MCOs should (1) permit patients to participate in meaningful clinical trials; (2) utilize outside organizations to evaluate trials' scientific adequacy beyond the obligatory institutional review board and thereby facilitate wise participation by the MCO and its enrollees and minimize disputes; and (3) utilize trial data to establish practice guidelines, clinical pathways, and standards of care.

**Maximizing Access to Proper Care**
Knowledge of coverage issues and appeals procedures within MCOs is a tool that oncologists providing specialty care for MCO enrollees can utilize to maximize patients' access to needed care. Knowledge of the disease management systems followed by local MCOs provide special opportunities for the oncology community to develop a partnership with, consult for, or collaborate with MCOs.

**Coverage Issues**—Traditional indemnity insurance has limits, in terms of both what and how much is covered. Essentially, a policyholder and insurer enter into a contract to transfer a risk in exchange for a fee. As costs increase, indemnity plans tend simply to increase premiums. In contrast, MCOs tend to cap coverage, provide incentives for cost-containment, and encourage efficiencies. Today's MCOs have little choice, given that they are the product of rapidly rising health-care costs.

An MCO enters into a contract with an enrollee to provide health care for a prepayment. This arrangement does involve risk on the part of the MCO (eg, determining how much health care the enrollee wants or needs during the period). Issues of what's covered and in what amounts still remain. However, MCOs generally offer a comprehensive benefits package that includes preventive services, which, by definition, cannot be covered by indemnity insurance.

**Denials and Appeals**—There is the perception, at least, that MCOs have a greater incentive to deny patients needed treatments. Under indemnity insurance, plans cover whatever doctors order, provided that it is a covered service, often paying a usual and customary fee. Managed-care organizations, on the other hand, may question an intervention's medical necessity; potentially, this may protect patients from treatments that cannot be expected to improve their outcomes, as well as possibly save money (although the cost of administering some programs may exceed any savings that accrue from refusal to cover unnecessary treatments). Nevertheless, a mechanism must exist for patients to appeal coverage decisions, and that mechanism must include referral to an external, impartial organization for review of the case's medical facts.

**Disease management** promotes the integration of services delivered by different organizations when these result in cost-effective care. Disease management is quality management focused on a particular disease. For example, breast care centers deal with the continuum of issues related to conditions of the breast in women. Breast care centers, which are found increasingly in academic medical centers or large group practices, provide an integrated system of care, including, when necessary, referral to specialized cancer care.

Childhood cancers provide another example: The Childrens Cancer Group (CCG) and the Pediatric Oncology Group (POG) have collaborated with the National Blue Cross/Blue Shield Organization on a project to ensure that core services essential to optimal pediatric cancer care are available in MCOs, contracting hospitals, or in the community from specialized centers (Blue Quality Centers for Pediatric Cancer). Furthermore, it is anticipated that in those plans that choose to participate, coverage barriers will be nonexistent for children who are being treated on CCG and POG protocols.

In principle, the ultimate goal of disease management is to minimize the life-time treatment costs of a disease, maximize patients' health status, engender a high degree of patient satisfaction, and, if necessary, choose acceptable trade-offs among these goals. In practice, disease management often boils down to minimizing treatment costs for a complete or extended episode of treatment or, in the case of chronic diseases, for ongoing management costs. Costs must be minimized in such a way as to be consistent with the achievement of maximal patient health status and satisfaction with care, however.

Whenever possible, disease management starts with prevention, which, if not cheaper than cure, at least provides better health status. The focus on complete episodes of care or ongoing care costs reduces the incentive to select individual interventions that have the lowest cost. For example, if an expensive intervention can cure the disease, it is preferable—from both cost and quality standpoints—to lifelong weekly visits to the doctor, which have a low unit cost but high aggregate cost. Of course, this is an obvious example, but it is the principle that is important. Disease management, like quality management, starts with sound, evidence-based practice policies for prevention, treatment, patient education, and so forth; involves incentives to do the right thing in the right way as efficiently as possible; requires cost and quality assessments; includes feedback of results to improve conformity with practice policies; and entails revision of these policies, when
What Is Proper Cancer Care in the Era of Managed Care?
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indicated, to improve patient health status at lower cost. At present, patients enroll in managed-care plans on a periodic (usually an annual) basis. There is a positive incentive for plans to retain members whose care costs less than their annual payments (but not to keep other members). Prevention programs can be fully funded because their cost is eminently calculable and attributable to types of enrollees. Covering the cost of treatment involves calculating the chance that an enrollee will develop the disease and the cost of the best subsequent treatment, as well as estimating the costs of caring for those who already have the disease. Prevention programs may detect more disease that requires treatment, and, in any case, usually involve more tests to rule out apparent disease discovered in screening programs. Although MCOs have a positive incentive to minimize the annual costs of treating a disease, they may also have every incentive to withhold expensive interventions. To some extent, every MCO faces the same set of risks so that they may represent a "wash." Nevertheless, MCOs that can hold down annual payments may attract more enrollees, and, assuming that annual costs for their care is lower than their payments, may result in more profits for the plans, through economies of scale. The oncology community can identify the practitioners in their area or elsewhere who offer the specialized expertise essential to provide MCOs with the information that they need to develop systems that will deliver services for optimal patient care.

Disease management is also an area in which the oncology community can exercise its role as community conscience. Oncologists should closely monitor the MCOs in their area to identify exclusions of classes of treatments aimed at making the plan unappealing to disabled or health-compromised patients. The Americans with Disabilities Act of 1990, the federal Rehabilitation Act of 1973, and the Kassebaum-Kennedy Health Insurance Reform Act of 1996 provide remedies for this type of practice.

Conclusions

Managed care leaves many fundamental health-care issues largely unaffected, such as the invention and introduction of new treatments, what's covered in what amounts, and universal access to affordable, quality health care. This new way of doing business also does not address inequity in the distribution of health-care resources; eg, the rich can afford better health care than the poor, they know how to "work" the system, they demand and likely derive more from health-care encounters, and they can afford to hire lawyers if something goes wrong (thus increasing the chance of winning a malpractice case). The reality is that practices of some MCOs may deprive patients of beneficial treatments and that recommendations of some providers may be ill-advised.

If the oncology community accepts the role of community conscience for cancer care, it can identify gaps and deficits in coverage and, with the help of patients and advocates, apply pressure to correct them. By streamlining operations, concentrating on needed trials, and eschewing premature promotion of new but unproven therapies off-trial (which consumes resources without providing knowledge), the oncology community can become an attractive partner of MCOs.

Given the right incentives, managed care can encourage and enable people to lead healthier, more productive lives and to improve value for money, through better health education, self-care, and prevention programs, for example, as well as the more efficient diagnosis and management of diseases.

The days of independent practitioners, usual and customary fees, and grateful patients are fading fast. Managed care is here to stay. The surprising result for most patients is better, less expensive care. For most practitioners, managed care will likely mean greater accountability and lower income. For all of us, managed care will also mean changed expectations and realities. The Kassebaum-Kennedy federal law guaranteeing access to and portability of coverage removes key barriers (other than price) to the ability of cancer patients/survivors to obtain or maintain health-care coverage. This law may allow cancer patients/survivors to join indemnity programs or shop around for the "best" MCO feasible, rather than making them captive to state-mandated "open season" plans.

The oncology community needs to watch out for the following tendencies:

- Health-oriented totalitarianism; permitting or requiring the MCO to be responsible for communities' health status. If taken seriously, this would mean that MCOs would become responsible for enrollees' behavior, and therefore, would have to provide enrollees with incentives to act in ways that were consistent with good health and/or that would minimize the expenditure of health-care resources.
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- Emphasis on short-term profits at the expense of long-term health status improvement
- Organization of MCOs for the industry's, rather than the patient's, benefit (as in heavily regulated industries, such as mail delivery, telephone service, energy utilities)
- Overpowering incentives to mindless conformity, for example, to rigid protocols that leave little room to tailor treatments to individuals' circumstances when appropriate
- Enforcement of social standards related to such technologies as genetic screening and genetic engineering to minimize health-care costs.
- An arbitrary return to single-tier health care that results in bureaucratic mediocrity for everyone now at the expense of a dynamic system that produces greater value for money and that benefits everyone eventually

The oncology community can take various steps to counter these tendencies. For example, oncologists can:

- View cancer care from a disease management perspective
- Improve value for money, for example, by conducting research to find cheaper, equally effective (rather than marginally more effective but costly) treatments
- Strive to become more efficient, for example, by streamlining care processes
- Become partners with MCOs in delivery systems that permit seamless integration of cancer care and follow-up
- Take on the role of watchdog to ensure that MCOs provide proper cancer care

It may prove difficult to convince much of the oncology community to become proactive partners in the era of managed care. Managed-care organizations have started the revolution without the participation of the oncology community. The responsible evolution of managed care to meet patients' needs for optimal care and to put necessary clinical trials enrollment on track requires the active and proactive participation of all segments of the oncology community. Oncologists, academic medical centers, specialized diagnosis/screening programs, and disease-specific organizations must forge partnerships with MCOs to ensure that patients receive proper cancer care in the era of managed care. If oncologists do not help by getting on the train, they will surely be run over, to the detriment of cancer patients.

Glossary of Key Terms

**Exclusive provider organization (EPO)**
A managed-care plan that covers only those services delivered by a specified provider network (except for emergency care, for example). Technically, an HMO is usually an EPO, except that the term "EPO" connotes a network akin to a PPO.

**Group model health maintenance organization (HMO)**
An HMO that contracts for services predominantly with a single, independent group practice, usually in HMO-owned or -managed facilities.

**Health maintenance organization (HMO)**
An organization that agrees to provide a defined (often comprehensive) range of health services to an individual (or group) for a specified period (usually a year) in exchange for a prospective (usually monthly) per capita (or sometimes per family) subscription (payment).

**Individual (independent) practice (physician) association (IPA)**
An entity that enters into an arrangement for the provision of health-care services with licensed medical practitioners and other health-care providers, often for the purpose of contracting with managed-care organizations to deliver services to their enrollees.

**Integrated delivery system (IDS)**
A health-care system under single management that provides primary care, secondary (specialist and hospital) care, and often tertiary (highly specialized) care, nursing home care, home care, and other services, usually to effect coordination of services and to achieve economies of scale. Sometimes called a vertically integrated delivery system.

**Managed-care organization (MCO)**
A broad term that refers to a managed-care plan or a managed-care company. It encompasses such entities as health maintenance organizations and preferred provider organizations, for example. Managed-care organizations combine both health insurance and health-care delivery functions. They usually deliver care to their enrollees (also referred to as
members or subscribers) through staff, an allied group, or a network of contracted providers.

**Managed indemnity**

A traditional indemnity health insurance plan that includes such elements of utilization management as preprocedure review, for example. Sometimes called managed fee-for-service insurance.

**Network (managed care network)**

An organization that provides health-care services to one or more defined populations (for example, individuals who enroll in the MCO or employees of companies that contract with the MCO for services). An HMO, PPO, insurer, or any other entity consisting of provider organizations and insurers may form a network to contract with purchasers to provide health care. An employer may create a network to provide care for its employees. The network's organizer coordinates and integrates services provided by the network's components, for example, multispecialty group practices.

**Physician-hospital organization (PHO)**

An entity created by a hospital and a physician group, usually to obtain managed-care contracts that the entity negotiates directly with employers.

**Point of service (POS) plan**

A managed-care plan whose members may choose their provider (and hence plan) at the time of service. Usually, the plan covers more of the cost of care if the patient chooses a participating provider (for example, care delivered by an HMO or within a PPO) and less of the cost of care if the patient decides to use a provider outside of the plan, with the patient making up the difference. Sometimes called managed choice.

**Preferred provider organization (PPO)**

An MCO that contracts with providers to deliver specified health-care services to a defined population (enrollees) at a discount. A PPO usually has the following three characteristics: discounted provider fees in exchange for a guaranteed volume of patients; monetary incentives for enrollees to use network (preferred) providers; and broad-based utilization management programs.

**Primary-care physician (provider, practitioner) (PCP)**

A individual who is a person's primary contact within the health-care system and who delivers or manages the person's routine health-care needs. In managed-care organizations, patients usually must first see a primary-care physician to obtain any needed specialty care (hence the term "gatekeeper").

**Staff-model health maintenance organization (HMO)**

An HMO that delivers services though a physician group that it controls; physicians are usually salaried employees of the group.

**References:**


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