From the Editor's Desk

John V. Cox, DO, MBA

Medicare's Seasons

By John V. Cox, DO, MBA

We all have a sense of seasons. Even if you live in Hawaii or Key West, you cannot avoid the marketing that defines each part of the calendar year. Medicare is a bit like this. Every year there are a series of calendar milestones that determine what changes will occur in the Medicare program for the following calendar year.

By law, before March 1, the Centers for Medicaid and Medicare Services (CMS) must publish data that outline the level of spending for payments to physicians for the coming year. With all the attendant uncertainties, how can the program accurately plan for burgeoning health care costs? Further complexity is added to the planning process by appropriation requirements to maintain budget neutrality. This process is governed by the evil genius of the sustainable growth rate (SGR) formulators. The SGR calculation pulls together data on the amount of dollars spent the previous year in Medicare, the growth in the economy, and the growth in numbers of Medicare beneficiaries to arrive at spending goals for the coming year. From the SGR calculation, a conversion value for 1.0 relative value unit is generated. (For 2009 this value is \$36.07.)¹ All physician fees in Medicare are paid based on codes that carry a relative value unit allocation (the way this is done is fodder for a different piece).

In midsummer, CMS publishes a series of proposed rules. These rules address everything related to practice under the Medicare program: reimbursement, documentation, quality measures, interpretations on conflicts of interest, definitions of ownership requirements, and so on. As governmental programs fund close to 40% of dollars in health care, these rules essentially define the way we practice medicine.

Next up, by November 1, after digesting comments on the proposed changes, CMS will publish the final rule, including an updated calculation of the conversion factor. Often within the rule will be requirements that are new or that mandate significant change in practice. Implementing instructions for these changes are often not released until within days of the start of the New Year, requiring providers to scramble to adjust to changes that take effect on January 1.

Since 1997, when the SGR methodology was put in place, the Medicare and the legislative calendars have been intertwined. Physician fees have been cut under SGR nearly every year. Recognizing the severe impact these reductions would have on Medicare beneficiaries and the health care system, physicians mobilize to lobby Congress. All of organized medicine descends on Washington each year, and each year the legislative branch has answered by at least temporarily halting the cuts.

Hence, the seasons of medicine churn. I am struck by Dr Penley's column this month and his rhetorical question: "Is this any way to construct a health care system?"² Certainly it is not, but it is our system and it behooves us to strive to understand it, and to realize the levers and limits at play. Some have felt that the system is unfair to our practice and specialty, but in reality oncology is just one group among many in medicine that struggles with the effects of the annual calendar. All of medicine must participate in seeking new solutions that address access and budgetary concerns. All of us must draw back and see the larger picture of health care, not simply remain focused on our self-interest.

In this issue of *Journal of Oncology Practice*, the reader will find an article reviewing the Medicare program.³ We need to fill in the gaps of our ignorance about the very program that governs our lives and affects many of our patients. Periodically, *JOP* will strive to provide articles in the same vein to outline the workings of the systems that affect our world.

Also in this issue is a commentary from Chris Stokoe, MD, a practicing oncologist, concerning the struggles of keeping abreast of our rapidly changing profession.⁴ As if to answer some of the concerns he raises, ASCO has created provisional clinical opinions (PCOs) to provide a rapid and authoritative voice that will opine on data that should affect practice. PCOs will help raise members' awareness of such changes and put new scientific developments into practice. Rocky Morton, MD, and Elizabeth Hammond, MD, discuss ASCO's first PCO on *KRAS* testing in metastatic colon carcinoma.⁵ Dan Haller, MD, and I comment on some questions and challenges presented by the PCO process.⁶

As always, the editorial staff at *JOP* seeks your input at editorsdesk@asco.org.

DOI: 10.1200/JOP.0921503

References

1. Centers for Medicare and Medicaid Services: Sustainable growth rates and conversion factors. <http://www.cms.hhs.gov/sustainableGRatesConFact/>
2. Penley WC: Random ruminations of a sports fan . . . J Oncol Pract 5:96, 2009
3. Overview of Medicare parts A-D. J Oncol Pract 5:86-90, 2009
4. Stokoe C: Adapting practice in the face of new data. J Oncol Pract 5:83-85, 2009
5. Morton RF, Hammond EH: ASCO provisional clinical opinion: *KRAS*, cetuximab, and panitumumab—Clinical implications in colorectal cancer. J Oncol Pract 5:71-72, 2009
6. Haller DG, Cox JV: Provisional clinical opinion. J Oncol Pract 5:73, 2009