From the Editor's Desk

Douglas W. Blayney, MD

With the new year, changes in two important federal programs are underway. The Centers for Medicare & Medicaid Services (CMS) will implement the 2006 Chemotherapy Demonstration Project. Office-based hematologists and oncologists will receive an additional payment of \$23 in conjunction with level 2 through level 5 established patient office visits for patients with one of 13 specified cancer diagnoses. This is the current iteration in what is likely to be a series of pay-for-performance or pay-for-data programs that CMS is implementing. The payments incorporated in this year's demonstration project are likely to be transitional, moving away from paying oncologists for the value they add to chemotherapy administration and toward paying for patient management. This issue's feature story explores the details of the 2006 Chemotherapy Demonstration Project; in our last issue, we reported on CMS Administrator Mark McClellan's future goals for the Medicare program and its payment schemes (*J Oncol Pract* 1:149, 2005). As professionals, our task going forward has to be to demonstrate the value we provide, and to ensure that we are paid appropriately for it.

The second change in the federal programs affecting oncologists and our patients this month is the much-awaited Medicare Part D program. Medicare beneficiaries who have elected to enroll will receive partial coverage for their prescription drugs through this payment scheme. We devoted much of our November 2005 issue to examining Part D, and we will continue to look at this program and its effect on our patients and our practices as it unfolds.

You may notice the recurring theme of quality measurement and improvement in our issues. We continue this theme with a "how to" on clinical practice guideline adherence in our Focus on Quality feature. Somerfield, Hagerty, and Desch provide background on the development and use of ASCO's evidence-based practice guidelines. This is especially topical in light of the Medicare Oncology Demonstration Project, which encourages guidelines-based care. Demonstration that our patient care is rendered according to established guidelines (including ASCO's) will likely play an increasingly important role.

Two of our legal commentators weigh in on the constructs available to oncologists to structure relations with hospitals. Paul Danello, of Ropes & Gray, LLP, in Washington, DC, discusses the concept of clinical co-management. This arrangement structures a relationship between a hospital and a group of physicians not only to provide patient care services, but to provide clinical input and to lead the hospital's infrastructure creation and its operations. He explains how these co-management arrangements differ from the common, single-physician medical director arrangements. Alice Gosfield, of Alice G. Gosfield & Associates, PC, in Philadelphia, Pennsylvania, is familiar to many of our readers but new to our pool of commentators. She offers background and advice on structuring hospital-physician alliances, examining the Stark statute, anti-kickback statute (AKS) of the Social Security Act, and the antitrust laws. In this context, she explores four strategies to help hospitals to assist oncologists in advancing their own business' case for quality by partnering with hospitals in new and unusual ways.

Though not a complete answer to the financial dilemmas faced by many patients paying for oncology care, copayment assistance programs have developed and may be useful for patients who lack health insurance or who have inadequate insurance coverage. The programs have been developed by individual pharmaceutical companies, by advocacy groups, and by others. We review these programs, as well as voluntary agencies providing support, in our feature story, and discuss how the programs might be affected by the Medicare Part D drug program.

Osteonecrosis of the jaw associated with bisphosphonate therapy is one subject of our Original Research contributions. Consensus guidelines for management of this recently recognized, but poorly understood and often devastating condition associated with intravenous bisphosphonate use are offered by Ruggiero et al. Recognition of patients at risk, maintenance of good dental hygiene, and avoidance of invasive dental procedures are measures which can be used in management of this condition. As Catherine Van Poznak, MD, points out in her Member Perspective article, these management guidelines result from the consensus of experts and, because we are early in our understanding of this illness, are not based on evidence from interventional or controlled interventional studies. They provide useful information, nonetheless.

Profiles in Success looks at a group in California's wine country, and how they have grown their clinical enterprise and clinical trial efforts. California has had fits and starts of managed care cost control efforts, and Wayne Keiser's Redwood Regional Medical Group has been in the thick of it. Their approach to growth, with its attendant economies of scale, to clinical investigation and to diversification has served them well. We also highlight three successful clinical trial award-winning practices, which were recognized at the 2005 ASCO Annual Meeting for their success in implementing clinical trials in their communities.

In Michigan, as we start 2006, the ground is predictably covered in white, and it's a slog through the snow to get to work. The new year brings the promise of renewal, and most of all of spring. My colleagues and I at the *Journal* wish you a fulfilling and prosperous new year, and hope to meet many of you personally and hear your ideas for the *Journal*.

Douglas Blayney