Commentary: Six Years of Trends in Oncology Practice Data

By Douglas W. Blayney, MD

Six years of accumulated oncology practice financial data are presented in this issue of *Journal of Oncology Practice* in a report by Barr and Towle.¹ Collection and presentation of this potentially sensitive financial information is a remarkable achievement. The authors and their organization (Oncology Metrics, a division of Altos Solutions) conduct yearly surveys of office-based, generally physician-owned practices (the traditional “private practice” or “community practice”) and have previously presented high-level data in *JOP* (for the most recent benchmark report, please see the upcoming November *JOP* supplement). Although there are potential biases in the study sampling methodology and analysis (see methodological footnote, Appendix [online only]), this report presents the most current real-world practice data publically available.

Three Eras of Oncology Practice and Organization

Barr and Towle have arbitrarily divided practice financing data into three periods: Stability (from 1991 to 2003), MMA (adaptation to the Medicare Prescription Drug Improvement and Modernization Act of 2003; from 2004 to 2006), and Squeeze (2007 to 2010). These periods might be more accurately characterized as “chemotherapy infusion migration,” “transition to Average Sales Price + 6% (ASP + 6) reimbursement,” and “reorganization.”

Migration of Chemotherapy Services

The period from 1991 to 2003 was a period of migration of chemotherapy infusion from the hospital to the physician-practice infusion center. Many oncologists—for purposes of patient convenience, better supervision of the infusion personnel, and more control over capital formation and personnel compensation—developed infusion centers integrated with their professional practice. Often, this development was encouraged by third-party payers, who found it less expensive to pay for care in the physician-owned infusion center than in a hospital-based infusion center.

These integrated practices could engage in the common health care practice of cost shifting. The profit margins from drug reimbursement subsidized poorly compensated patient services (including clinical trial participation, provision of cancer support services, and outreach clinics to underserved areas). In 2003, when legislators addressed changes in reimbursement methodology for oncology drugs, they focused on drug margins and physician compensation. The resulting MMA provisions discouraged provision of chemotherapy infusion services by integrated practices by reducing the margins available from chemotherapy infusion.

MMA Adaptation

Implementation of the arbitrarily defined and poorly tested ASP + 6 chemotherapy reimbursement was cushioned by transition payment schemes, but caused a temporary decrease in the per-oncologist revenue curve (Barr and Towle’s Figure 8). The authors tell us that they have inside knowledge of their data sources, and they speculate that a decrease in the use of erythropoietin-stimulating agents accounts for the decrease in supply costs between 2006 and 2007 (Figure 1), and a reduction in revenue 1 year later. The predictable consequences of this reimbursement change have led to the Squeeze era.

Squeeze, or the Era of Multiple Adaptation Strategies and Reorganization

Data on practice cost and revenue per established patient visit (Figure 7) and cost and revenue per full-time equivalent hematology/oncologist (FTE HemOnc) (Figure 8) suggest that a squeeze between costs and offsetting revenue is occurring. Costs for drugs and supplies, despite the disincentive to provide chemotherapy infusion services, continue to rise more quickly than revenue. Though some practices continue to match revenue declines with cost reductions, this instability clearly threatens the business viability of some practices.

Some Useful Context to Assess Future Predictions

Capital for Expansion, Growth, and Process Improvement

Viable businesses need capital to expand and grow, to improve productivity (by implementing new technology), and to attract talent. In medicine, there are three potential capital sources: physicians, pharmaceutical companies, and hospitals and other large institutions.

For the traditional physician practice, the practice’s physician-owners are the usual source of capital. Barr and Towle’s data suggest that in the Squeeze era, margins to generate capital will be unavailable. The ability of physicians as individuals or corporations to form capital, to take on risk by tapping personal or bank lines of credit, or to reinvest profits back into the practice will be limited. Pharmaceutical companies, because of actual and perceived conflicts of interest, are not a current capital source for physician practices.

Hospitals, when efficiently managed, generate margins that can be used as capital. In addition, they are influential with legislative and regulatory bodies, and have been able to retain their reimbursement increases from government and private purchasers of health care.

Positioning for Implementation of Health Care Reform

The Patient Protection and Affordable Care Act of 2010 established a framework for reorganization of the US health care delivery system, including regulatory implementation of Accountable Care Organizations (ACOs).⁴ ACOs are intended to bring physicians into an integrated system, which shares the rewards of efficient, coordinated patient care among its participants. Initially proposed regulations creating ACOs⁵ were controversial, and even model organizations threatened nonparticipation.⁶ Further, the authorizing legislation is in jeopardy. Nonetheless, it is likely that some form of integrated care organizations, whether established by law or by experimentation in the marketplace, is coming.

Four Predictions

The Squeeze Persists

It is almost certain that the Squeeze will persist. There are unlikely to be new sources of revenue appearing. The value of targeted cancer therapies, reduced toxicities, and more convenient drug administration to patients has been captured by pharmaceutical manufacturers. Oncologists—who provide counsel to patients, manage the adverse effects of the cancer and its therapies, and provide infusion services—will be hard pressed to compete to recapture the value we provide to patients in the eyes of third-party purchasers of oncology services.

Pace of Continued Efficiency Improvement Falters

We can be more efficient. In the early days of the personal computer, it was said that computers were showing up everywhere but in the productivity statistics. We are in a similar situation today. There are limited data suggesting improved physician productivity after the introduction of electronic health records; the existing systems are only beginning to be effectively integrated into physician workflow. The ACO, if effectively implemented, may reduce the number of personnel currently required for billing and collection. I am also convinced that there are patient services, which are currently rendered by oncologists, that can be effectively delegated to nonphysician providers.

Service Delivery Per FTE HemOnc Peaks

The key here is the definition of “service delivery.” Parsing and appropriate delegation of tasks to the appropriate allied health practitioner, palliative care specialist, or other practitioner is one way to improve oncologist productivity according to Barr and Towle’s measure.

Labor Cost to Increase Faster Than Revenue

The straight line fitted to the data shown in Barr and Towle’s Figure 4 suggests that at the current rate, practices will add one FTE support staff per full-time physician every 3.5 years. Participating practices incurred expenses of \$2.5 million per FTE HemOnc for medical and surgical supplies (almost certainly for

drugs administered in the practice’s infusion center), and the other costs of running the practice are approximately \$1.5 million per FTE HemOnc. These other costs likely include overhead expenses such as facility rent, insurance, utilities, and \$450,000 for the eight staff members used to support each oncologist (Figures 4 and 5). Labor costs will likely continue to rise, but there is opportunity for either substitution of technology (such as automated registration), or appropriate use of less highly trained, specialized, and compensated labor (eg, nurses should do nursing work, not clerical work).

More Predictions

Innovation Will Suffer If Private, Community Practices Disappear

Community-based practices have been sources of innovations in customer service, information technology, and medical treatment. They contribute the majority of patients to cooperative group clinical trials. In an era of reorganization and chaos, community practices should continue to be a source of innovation. ACOs, in whatever form they take, can benefit from the creativity and experimentation of innovative community-based practices. Traditional physician-owned, community-based practices are in for a rough ride.

The Next Era

In the absence of self-generated sources of capital, physicians are gravitating toward a convenient source of capital, their affiliated hospital. Hospital acquisition of physician practices represents consolidation of two sources of capital. Medical Group Management Association data show a trend toward more employment of physicians by hospitals and other holders of capital.³

Whether these consolidations will endure is an open question. Will they unwind as third-party payers again seek to realize potential cost savings of office-based versus hospital-based infusion? Will the potential economies of scale from physician-hospital consolidations be realized? Will patients rebel against the often impersonal and inconvenient hospital-based infusion center? Will hospital employment become less attractive to physicians? Will Barr and Towle’s Squeeze era be followed by chaos; by reorganization of oncology service lines within an ACO model; or by re-emergence of privately held, efficiently run, multidisciplinary oncology care as we build the next era? All these are questions worthy of consideration.

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Commentary: Can You Replace Something With Nothing?

By David Eagle, MD

High-quality oncology care includes many indispensable elements: care coordination, treatment planning, supportive care, and palliative care. Delivery of these services requires appropriate amounts of staff, space, and resources. In the past, profit margins on drugs were used to pay for the provision of the many essential services that have been and continue to be unreimbursed. One of the goals of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was to move away from drug margin by transitioning from an average wholesale price (AWP) model to an average sales price (ASP) model as a means of determining reimbursement amounts. To replace the use of AWP, Medicare augmented its coding and payments for infusion services in an incomplete attempt to better match payments to the services oncology clinics actually perform.

Medicare payments for infusion services have been serially reduced every year since 2004. Current payments for infusion services have declined 35% since 2004. When adjusted for the medical economic index, a practice expense adjustment, the decline has been 47%. (Figure 1) Fearing potential shortfalls, Medicare implemented demonstration projects to provide supplemental funding in 2005 and 2006. After 2006, the demonstration projects were not renewed.

A partial explanation for these payment reductions includes the most recent American Medical Association (AMA) practice expense survey conducted in 2008. The survey was not specialty specific and included only one question regarding infusion services. Survey data were received from fewer than 60 oncologists nationwide. Nevertheless, based on analysis of the AMA survey and older data, the Centers for Medicare & Medicaid Services proposed a 20% reduction in infusion service payments. As a result of thoughtful opposition from the oncology community, the infusion service payments reductions have been partially mitigated.

Recognizing the fundamental misunderstanding of government and private payers regarding oncology practice expenses, the Community Oncology Alliance (COA) and Avalere Health conducted a Components of Care study that collected detailed survey data from 499 oncologists for calendar year 2008.¹ Analysis of practice expenses for the provision of infusion services determined that Medicare payments covered only 57% of the cost of providing these services to beneficiaries.

Over the past several years, private payers have slowly migrated to an ASP payment model for drugs. Because this transition has been gradual, the full impact of the ASP system has only recently become apparent. The end result has been that current government and private payer payments for infusion and cognitive services do not nearly compensate for the reduced drug margins under the ASP system. The current payment system has thus effectively tried to replace something with nothing, and the result has been the widespread failure of private oncology clinics. COA has compiled a practice impact report that demonstrates this graphically (Figure 2).² Multiple practices across the country have closed, merged with other entities, or been sold to hospital systems.

The National Oncology Practice Benchmark study³ provides invaluable data to illustrate the financial impact of these changes on practices. One strength of the data is that it has been collected in a similar, but not identical, format over several years. It likely represents the largest compilation of oncology practice financial data in existence. It is important to remember, however, that financial data were collected from different practice participants each year. The groups that have contributed data over the past few years are the survivors. In an earlier iteration of the National Oncology Practice Benchmark, it was reported that physician-owned