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References

1. Barr TR, Towle EL: Oncology practice trends from the National Practice Benchmark, 2005 through 2010. *J Oncol Pract* 7:286-290, 2011
2. Jemal A, Siegel R, Xu J, et al: Cancer statistics, 2010. *CA Cancer J Clin* 60:277-300, 2010
3. Kocher R, Sahni NR: Hospitals' race to employ physicians—The logic behind a money-losing proposition. *N Engl J Med* 364:1790-1793, 2011
4. Patient Protection and Affordable Care Act of 2010, Public Law 111-148—Mar. 23, 2010, 124 Stat. 119. <http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>
5. Berwick DM: Launching accountable care organizations: The proposed rule for the Medicare Shared Savings Program. *N Engl J Med* 364:e32, 2011
6. The Accountable Care Fiasco. *Wall Street Journal*, Review and Outlook, June 19, 2011, <http://online.wsj.com/article/SB10001424052702304520804576343410729769144.html?KEYWORDS=accountable+care+organizations#articleTabs%3Darticle>, accessed July 8, 2011

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

Figure 1. Decrease in Medicare reimbursement for infusion services since 2004.

oncology practices declined from 87% of respondents in 2007 to 71% in 2009.⁴ It is likely that the data being analyzed greatly underestimate the true magnitude that changes to the payment system have had on the financial condition of practices. Many practices that were affected the most are no longer around to contribute data.

The report accurately describes phases of stability (1991-2003), MMA adaption (2004-2006), and squeeze (2007-2010).³ The squeeze phase began when no additional demonstration projects existed to provide supplemental funding. Reductions in payments for infusion services and gradual private payer adoption of the ASP drug reimbursement model have contributed to the squeeze.

One should not necessarily conclude that the ASP methodology has resulted in some bending of the cost curve for oncology drugs. The report correctly describes the effect of reduced usage of erythropoietic stimulating agents on total amount spent on drugs by oncology clinics. However, when interpreting overall trends in drug spending, one must be mindful of the shift of many treatments from physician-owned clinics to the hospital outpatient setting. One critical effect of MMA is that patients who have Medicare coverage without coinsurance are generally treated at a loss in private clinics if the patients are unable to afford their 20% drug payment burden. Most pa-

Figure 2. Nationwide impact of reduced payments.

tients cannot afford this expense. Furthermore, Medicaid payments in many states have been curtailed, which has similarly forced patients into hospital outpatient infusion centers. Therefore, the trajectory of total drug spending for oncology care is predictably higher than the National Oncology Practice Benchmark data illustrate.

The data from the National Oncology Practice Benchmark have been and continues to be invaluable in analyzing the financial metrics and trends for the operation of oncology clinics. For years, many stakeholders in oncology have been anticipating the tipping point at which private clinics become financially nonviable. As the practice impact report demonstrates, the future is now. Any additional reimbursement reductions for oncology are certain to drive more practices under. Therefore, the question now is not, "Where is the tipping point?" but rather, "Is this current failure of private clinics undesirable?"

Many private payers appear to realize that their total spending on oncology care is increasing with the gradual disappearance of private oncology offices. The false narrative has been that private practice oncology offices represented cost centers practicing on the basis of perverse incentives that led to overutilization. Payers are now starting to recognize private offices as the most efficient oncology care delivery model.

If payers do not want to return to the past of financing oncology clinics through drug margin, then their only choice is

to truly recognize the practice expense for operations and reimburse it in a more viable format. The "experiment" of replacing something with nothing has been proven to be unsustainable for private oncology practices.

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References

1. Avalere: Providing High Quality Care in Community Oncology Practices: An Assessment of Infusion Services and Their Associated Costs. <http://www.communityoncology.org/docs/Avalere-COA-Components-of-Care-Study-Final-Report.pdf>
2. Community Oncology Alliance: Community Oncology Cancer Care Practice Impact Report: Documented Impact on Community Oncology Practices. <http://www.communityoncology.org/UserFiles/files/87f3205e-ee73-4b03-85fb-094870cc430d/>

COA%20Community%20Oncology%20Practice%20Impact%20Report%203-11(1).pdf

3. Barr TR, Towle EL: National oncology practice benchmark: 2011 report on 2010 data. *J Oncol Pract* doi: 10.1200/JOP.2011.000402
4. Barr TR, Towle EL: National oncology practice benchmark: An annual assessment of financial and operational parameters—2010 report on 2009 data. *J Oncol Pract* 7:2S-15S, 2011 (suppl)

Economic Assessment of the Association of Northern California Oncologists Member Practices

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Abstract

In late 2009 and early 2010, the Association of Northern California Oncologists conducted an economic assessment on a volunteer sample (n = 14) of northern California state oncology society member practices to measure key economic factors, diagnose economic viability, and prescribe changes to practice management to enhance practice eco-

nomics viability. Recommendations for individual member practices as well as for the state oncology society were made as a result of the findings of this study. Results from follow-up interviews conducted with study practices approximately 1 year after the original assessments reveal that most recommendations were implemented and seem to have generally strengthened the economic performance of the practices.