Expanding the Scope of the National Practice Oncology Benchmark Would Be a Critical Source for Understanding Outpatient Oncology Practice Costs and Profits in a Time of Change

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The National Practice Benchmark for Oncology annual report is a critical source of information regarding oncology practice costs, revenues, and profits. There are important lessons to be learned from the latest Benchmark reports. They also raise key questions for future study linked to ongoing reform efforts.

First, both “The National Practice Benchmark for Oncology, 2014 Report on 2013 Data”¹ and “Oncology Practice Trends From the National Practice Benchmark”² report results suggesting that the costs of purchasing drugs for the treatment of patients remains the most significant aspect of oncology practice costs and profit.

Acquisition costs of the drugs seem to be increasing substantially over time, particularly when we compare the level and trends reported in Figure 1 of the Oncology Practice Trends report² before and after 2004. This is likely related to several factors: innovation and the use of new drugs with high launch prices,¹ price increases among existing medical benefit–covered drugs,² and the increasing prevalence of treatment for certain cancers among the practices. It would be illuminating to understand in more detail the main drivers of these practice costs by drug characteristics (branded versus generic; oral versus infused/injected; therapeutic class and/or mechanism of action; distributed via limited specialty pharmacy network or open access) and for the treatment of which cancers, by stage and line of therapy.

Second, starting in the mid 2000s, total operating costs of the practices (reported in Figures 1 through 3 of the Oncology Practice Trends report²) seem to be increasing and diverging from drug costs alone. This is an intriguing finding for several reasons. Previous reports suggest that it is coincident with national community oncology practices shifting from small, independent practices to larger entities through affiliations, mergers, and acquisitions.^{3,4} For example, the “National Oncology Practice Benchmark, 2012 Report on 2011 Data” reported that the share of participating physician-owned private practices in oncology declined 10 percentage points between 2010 and 2011, whereas merger and acquisition activities between community oncology groups and hospitals and large provider groups increased substantially.⁵ Thus, I wonder whether some of the slowing of drug costs as a percentage of total operating costs has to do with the benefits of such organizational change, including access to 340B drug acquisition cost discounts, as well as significant volume discounts extended through exclusive contracting

Read the National Practice Benchmark articles published in the November 2014 issue of *Journal of Oncology Practice*:

1. Towle EL, Barr TR, Senese JL: The National Practice Benchmark for Oncology, 2014 Report on 2013 Data. *J Oncol Pract* 10:385-406, 2014
<http://jop.ascopubs.org/content/10/6/385.full.pdf+html>
2. Barr TR, Towle EL: Oncology Practice Trends From the National Practice Benchmark. *J Oncol Pract* 10:407-410, 2014
<http://jop.ascopubs.org/content/10/6/407.full.pdf+html>

with group purchasing organizations for selected participating practices. This would also explain why net revenue derived from the use of drugs alone (sometimes called drug margin) between 2005 and 2013 (Figure 4 of the Oncology Practice Trends report²) does not seem to be substantially declining among participating practices. Systematically understanding how access to these discounts may alter the trajectory of practice costs and revenues is an important topic for future work.

Third, we learn from these reports that practice costs and revenue (Figures 4 and 5 of the Oncology Practice Trends report²) are increasingly derived from nondrug services. We can observe the diversity of these services in Figure 3 of “The National Practice Benchmark for Oncology, 2014 Report on 2013 Data” and their contribution to practice revenue mix in Figure 40 of the same report.¹ Notably, practice revenue derived from evaluation and management activities, other medical activities, and imaging seems significant. For stakeholders who are interested in better understanding what makes oncology practices resilient in the face of change, it would be important to understand how the levels and trends of these drug and nondrug costs and net revenues differ in the cross-section and over time by practice size, organizational structure, and location.

Last, a quick glance over the names of the 2013 Benchmark Successful Survey Participant organizations (Table 1 in the Oncology Practice Trends report²) underscores the fact that the practices that are reporting data into the Benchmarks are unusual. As the authors of the Benchmark reports rightfully note, the practices providing data for the annual surveys are highly selected; their experience of success may not be representative of all oncology practices in the United States.

Nevertheless, as quality-of-care metrics and payment reform pilots get underway in oncology, we are in need of nationally representative data on outpatient oncology practice costs and revenues. In future data collection efforts, Benchmark investigators might consider the collection of specific information from practices on whether and which improvement programs they are participating in, including accountable care organizations and pilot payer episode-based payment models that are linked to specific cancer types. Participation in these activities likely requires significant investments in staff and information technology and access to capital to make such investments when needed. National data regarding these costs and potential practice revenue opportunities would be instructive to practices that are grappling with fundamental change, even if such data are drawn from a selected sample of practices. Thus, expanding

the scope of reporting by the National Practice Oncology Benchmark would be a critical source for assessing practice-level effects of imminent national policies to improve the quality of cancer care delivery and rein in costs.

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AUTHOR'S DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

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