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## A new year, a new era

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**O**n January 1, 2005, the new oncology era officially began. After more than 2 years of discussion, lobbying, education, rallies, letters to the editor, etc, profound changes engendered by the Medicare Modernization Act (MMA) of 2003 are being felt—heavily. The present reimbursement method will be marked by a period of confusion and adaptation as practices struggle with an untested and underfunded system.

This issue of *Community Oncology* features an interview with Mark McClellan, the new administrator of the Centers for Medicare & Medicaid Services (CMS) (see page 67) who is ultimately responsible for the success of the MMA. We asked him the questions our readers have been asking themselves, and his comments are as interesting for what they reveal as for what they do not reveal. Using Dr. McClellan's interview as a springboard, the beginning of the year is an excellent time to take stock of the past and look forward to the future.

### Coming together

Practicing cancer doctors and nurses have realized there was a critical need for a broader community dialogue beyond what has been provided by our established organizations. Indeed, this journal in large part owes its very existence to this deeply rooted need. Spurred on by impending change in reimbursement, community oncologists found new ways to communicate, share ideas, make their voices heard in Washington, and describe their mission and vision to patients and healthcare providers.

The importance of community oncology as a delivery option for the world's finest cancer care is proudly acknowledged by the many thousands of individuals who make up this section of the cancer community. Our diversity of solutions to problems gave rise to a network concept where innovation is quickly adopted across the country.

### Quality of life

Seemingly out of nowhere, CMS announced a \$300 million demonstration project to collect data

in several important symptom areas. Cynics view this as Medicare throwing a bone to ease our pain in 2005 by temporarily replacing some lost dollars. To use another metaphor, it's the "frogs in a pot" approach: If the heat rises slowly, the frogs get used to the temperature and they never jump. They don't get uncomfortable until the water boils, and by that time, it's too late. CMS may well believe that we are more likely to capitulate if they gradually ratchet down reimbursement rather than make a drastic cut.

Was the demonstration project politically motivated? The timing of its announcement 2 days before the election certainly seems to suggest that. Whatever the case, the government is validating the worth of collecting quality-of-life data, even if it is a relatively crude determination of just a few symptoms not adjusted by baseline comorbidities, prior symptom history, or disease status.



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This is a new paradigm—a change in mind-set that should be shouted from the rooftops. But why just a 1-year demonstration project? Capturing cancer symptom measures and addressing symptom relief should be a fundamental goal of oncology practices, one that is reimbursed on an ongoing basis.

### Sweat equity

The initial proposals on the table for oncology in 2002 did not survive to become a part of MMA. For those who view with resignation the changes that have occurred, keep in mind we could easily have gone from average wholesale price – 5% to a system of drug acquisition costs + 0%, with no increased reimbursement for administration services. Why this didn't happen has little to do with fairness, logic, or luck and everything to do with professional lobbying, intensive educational efforts, and the grass roots coalition formed to explain how community oncol-

ogy delivers care to millions of individuals throughout the country.

Unfortunately, the short time frame between the passage of MMA and the implementation of the new system beginning January 1, 2005, did not allow for adequate planning for use of methodology based on average selling price (ASP). Dr. McClellan implies that the new system is ready for prime time. But with all due respect, I am inclined to disagree. The law of unintended consequences predicts that commercial carriers won't pay us for months—if ever—since the new G codes are not yet set up in their computers. My own practice's analysis of cost and reimbursement for common regimens confirms many will be under water, even with 100% co-pays. Practice patterns are likely to undergo seismic shifts. Because Congress refused to place a safety net under the new system, it will cost the American cancer care delivery system a lot more than analyses of the ASP model suggest.

### **What should happen**

Throughout this year, we'll learn the true weaknesses and strengths of the new reimbursement system as it evolves. It will be more important than ever to stay engaged and to communicate with our colleagues, representatives, and patients.

We also need to communicate with the pharmaceutical companies. As they develop expensive new medications, we must work proactively on ways to provide fair reimbursement of these medications. In a field with more shades of gray than clear black-and-white answers, choosing the correct regimens, lines, and duration of therapy is difficult enough without having to add cost to the mix.

We need to publically discuss what will surely be decided on an ad hoc basis in each practice. Do all patients get offered the most advanced cancer care or only those who have co-insurance? Are we entering an era where patients must weigh how much 5 extra months of survival is worth? We urgently need a national dialogue with all interested parties.

### **What should not happen**

Complacency is our worst recourse. If community oncology shrugs its shoulders or congratulates itself on a job reasonably well done and believes we

now need to live with the consequences, the efforts of the past 2 years will have been wasted.

More than ever before, having an equitable system of cancer delivery depends on all of us in the trenches. We can't depend on national organizations to represent us if we don't stand up and make our voices heard. We can't expect the new Congress to feel sorry for us having to make sense of a new system. We can't expect them to solve our issue of the missing co-pay now that most regimens are under water. And we can't expect the situation to stay the same. Every other physician group will still be in Washington pressing its own case as to why it deserves more of the shrinking medical dollar.

Most importantly, on the horizon and coming very quickly on January 1, 2006, is yet another new system of cancer drug delivery, the mandatory vendor imposition or competitive bidding system, which could make ASP look like a godsend.

Ask your patients what they want: First is to live, second to live free of symptoms and as close to normal as possible, and third is to live free of fear that all of their worldly possessions will be stripped in paying for the care they need. Clinical oncology exists to help fulfill these expectations as much as we are able. Today this means knowing more than response rate and survival statistics. In order to treat the whole person, we must keep that person's life circumstances in mind and advocate for affordable care for all. A solution will require an equitable financial reimbursement process that truly covers the cost of delivering complex care.

A new year always delivers fresh hope and the promise of rebirth. It's our collective nature as oncologists to be both optimistic and inquisitive. The outcome for cancer care in America remains in our hands. I wish all of our readers and their patients a happy, healthy, and productive 2005.



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