

Good point; here's what we're doing

By Lee S. Schwartzberg, MD

Founding Board Member, Community Oncology Alliance, Washington, DC

Dr. Klepper has written a provocative piece suggesting that community oncology should clean up its act. Citing an article published in a relatively obscure journal and interestingly elevated to national news status by *The New York Times*, he wonders why oncologists, represented by their advocacy organization, Community Oncology Alliance (COA), react so vigorously to the conclusions.

Let's examine the evidence, beginning with the *Health Affairs* study cited by the *Times* and Dr. Klepper. This survey, using data from the previous decade and a now-abandoned reimbursement system, showed that medical oncologists used more expensive treatments when they were reimbursed more.¹ But one potential hypothesis for the central finding was not considered: newer and more effective agents are more expensive and therefore may generate greater revenue. Actually,

it's reasonable to accept the results of this study regardless of the underlying causes. Given the nature of the claims-based methodology used, those causes could not be elucidated. But regardless of cause, economic drivers do have a role in medicine.

However, it's critical for readers to understand that the reimbursement system analyzed in the *Health Affairs* paper was not designed by physicians in a grand Machiavellian scheme to deceive the government and rip off our patients. Like all federal reimbursement systems, legislators created the structure, and like all systems, there were inherent problems. The AWP (average wholesale price) method resulted in a cross subsidy, paid for by the margins on some drugs, for all the expenses associated with delivering chemotherapy in the outpatient system. Essential services such as drug storage and maintenance and chemotherapy preparation and administration were

woefully under-reimbursed, at below the cost to deliver the service. Other services integral to quality cancer care, such as educating patients about side effects, call backs after chemotherapy, and support groups, have not been reimbursed at all. All agreed that the system needed revision.

Changing the system

When the Medicare Modernization Act (MMA) was being discussed on Capitol Hill more than 3 years ago, oncologists led by COA were the first to advocate for a change in this flawed structure. In many ways, the new scheme, based on "average sales price," or ASP, is indeed much more transparent and reduces many of the perceived inequities on the drug-reimbursement side.

Unfortunately, serious flaws remain: ASP + 6% does not even cover the true costs of acquiring the drugs, leaving the practice under water. This means

that practices lose real dollars; they lay out the full costs to purchase the drug, but are reimbursed less than the full cost by Medicare. Although the fees associated with chemotherapy administration were modestly increased, reimbursement for the administration of toxic chemotherapy regimens remains woefully inadequate. It is technically complex and costly to deliver these drugs safely and effectively.

Dr. Klepper might argue that this is all a smokescreen, that oncologists have been complaining every year since MMA went into effect while continuing to profit. He might be surprised to learn that the members of Congress who crafted and supported the MMA are themselves concerned about the inequities of the current system as it relates to medical oncology. At least three pieces of legislation have been introduced into the current congressional session addressing oncology-specific reimbursement issues. One of these, HR 4098, The Community Cancer Preservation Act, has no fewer than 73 co-sponsors; a recent companion bill in the Senate (S 2340) has four co-sponsors. Hopefully we will soon have a legislative fix to the worsening reimbursement problem.

Let's acknowledge that community oncology care is expensive and getting more so, with an explosion of costly but effective new drugs and an expanding pool of patients. Let's also recognize that community oncology is in effect a set of small businesses that—to their credit—have transformed cancer care from an inconvenient hospital-based delivery system to an outpatient, office visit experience. Frankly, no business can survive long by losing money. If reimbursement doesn't cover drugs and services, something has to give. In the first quarter of this year, we've truly begun to see the effect. Patients

without co-pays are being sent to the hospital for treatment; satellite offices are closing; oncologists—who traditionally see a high number of Medicare and Medicaid patients—are reluctantly beginning to turn people away because these physicians simply cannot afford it anymore.

Seeing reality

I do agree fully with Dr. Klepper that we need to do a better job proving we are delivering quality care. Documentation and analysis of practice patterns is expensive and onerous, yet it must be done. Oncologists and other stakeholders are concerned about the rapidly rising costs of healthcare. We believe that, by and large, we are not delivering excessive treatment or inadequate care, but appropriate therapy for the 86% of American cancer patients under our purview. The vast majority of oncologists don't want to be tarred by the small numbers who take advantage of a complex system.

I also fully agree that greater transparency regarding the delivery of cancer care is warranted. Much progress is already being made in this area. Through the 2006 demonstration project, CMS itself is tracking diagnosis, stage, reason for office visit, and national guideline usage with every visit for the most common cancers. Early reports suggest that community physicians are participating heavily in this effort, despite a minimal reimbursement for providing the necessary data. This information will be of great interest to us all when analyzed and presented.

Published evidence to date demonstrates overall good to excellent cancer care delivery over a large number of domains.^{2,3} Currently, health plans, networks, employers, and multiple

healthcare agencies are involved in a number of innovative projects identifying methods to collect and validate the benchmarks of quality and cost-effective cancer care.

What more can we do? As Dr. Klepper suggests, we need to compare the costs of cancer care across all types of practitioners. This is not an easy task, as there is not yet any central clearinghouse or even a mechanism to submit data. Perhaps as electronic medical records take hold, these data will become available. Moreover, the entire spectrum of costs needs to be considered, including the indirect costs and savings associated with receiving care locally rather than spending enormous time and money to travel to a central location.

Community Oncology, the journal, wholeheartedly supports the quality initiative now gaining momentum in medicine and medical oncology. Part of our mission is to communicate best practices so all community cancer providers can increase efficiency and effectiveness in combating this dread disease. In this, I know Dr. Klepper and I have no difference of opinion.

References

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