Oncologist compensation deserves evidence-based scrutiny and analysis

As community-based oncology practices have faced continued cutbacks in reimbursements under the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) and now through sequestration, many have had to close satellite sites, cut back on their supportive services, join networks – where possible – or hospitals or health systems, and scramble to engage payers in rethinking payment models. They have done so not only to cover their costs for the technological outlay, staffing, and other overheads necessary for them to provide quality oncology care, but also to ensure competitive compensation packages for their teams of highly trained, specialized physicians, midlevel practitioners, and nursing and administrative staff.

Over the past 20 years, as entrepreneurial oncologists segued from their rigorous and protracted academic training into community-based practices where they could deliver quality oncology care and improve patient access to that care, they built businesses based on a national payment model that underpaid for diagnosis, management, and infusion services, but paid increasingly well for the growing drug margins as new agents came to market. That allowed community oncologists to invest in extended support services at the site of care, such as payment assistance, nutritional advice and support, and psychosocial counseling, as well as foot the bills for the costly transition to electronic health records, participation in valuable clinical trial programs, and state-of-the-art diagnostics and radiation therapy equipment. The rise in practice income also allowed for higher levels of physician compensation that were commensurate with those in the private business sector. As more therapies came to market at ever higher costs, however, the growth of oncology drug spending rocketed past the growth of the economy, and community practices became an easy target for reductions in reimbursement through the MMA (Figure 1). Those reductions eroded the practice's ability to balance the accumulated increases in the costs of care as well as the technical and staffing expenses. Throughout these transitions in the business of oncology, community oncologists were paid primarily from the "leftovers" of the practice, that is, whatever was left after paying practice overheads was the amount available for physician compensation.

We have now reached a point at which the increases in health care premiums on the private side and the cost of care on the governmental side are unsustainable. With premiums and out-of-pocket expenses primed to take 50% of the average American's salary by 2016 and 100% of the average salary by 2022, the payment and delivery system has to change, and it must change now. Physicians have borne the brunt of payment cuts, with evaluation and management code reimbursements, infusion service costs, and practice overhead reimbursements steadfastly lagging the consumer price index as margins on drug payments continued to decrease (Figures 2 and 3). During this same 20-year period, better organized but non–practice-integrated business consultants, specialty pharmacy groups, care management companies, and preauthorization programs have been used and well funded by payers to lower their medical costs without success. At the same time, practices – both community and academic – have faced continued payment cuts and inadequate rate adjustments in the face of their rising practice costs, which has created issues around physician compensation that have become critical. Physician compensation must be addressed through evidence-based analysis and discussion that will deliver comprehensive guidelines so that our compensation is no longer drawn from the leftovers: highly specialized and accomplished oncologists should receive premium compensation. In particular, the compensation must take into consideration the minimum 14 years of training oncologists undergo, which leaves them with a

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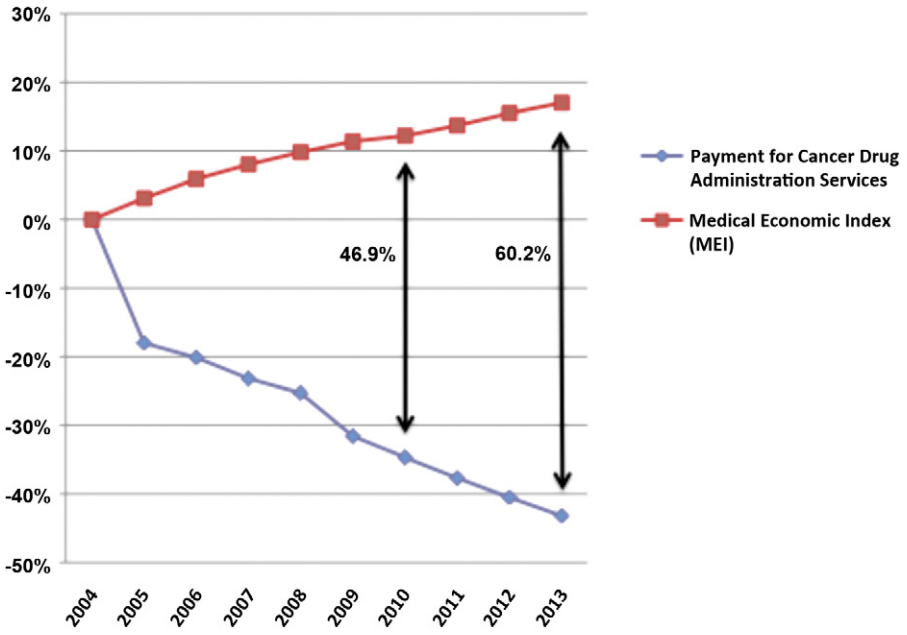

FIGURE 1 Medicare payment cuts to cancer care since 2004. The effective payment cut, factoring in cost increases for staffing, materials, and facilities MEI was 46.9% in 2010 and is projected as 60.2% for 2013. Figure is based on the assumption that there is no further cut from sustainable growth rate reductions. Reproduced with permission from Community Oncology Alliance; data source, Centers for Medicare & Medicaid Services.
Abbreviation: MEI, the Medical Economic Index.

significant amount of accumulated student debt and effectively 14 years behind their peers in most other professions in building their financial life, making pension plan investments, and growing equity in business or real estate, not to mention the significant personal sacrifice of family and leisure time outside of the training experience.

The 340B program, which requires drug companies to discount their drugs to facilities that treat indigent or uninsured patients, is being criticized for giving hospitals that participate in the program an unfair advantage in recruiting oncologists as either hospital employees or affiliated professionals. Many are now challenging the use of 340B by hospitals for nonindigent care as well as the higher reimbursement rates hospitals have negotiated for outpatient care as unnecessarily burdening payers with higher medical costs and patients with higher copays. But there is another side to that argument. Although many leaders and groups in the oncology community have argued for appropriate reimbursements for practice costs, overheads, and psychosocial, research, supportive, and other critical oncology services, neither the Centers for Medicare and Medicaid Services nor the payers have responded in a timely way with programs and rates that are needed to sustain community oncology. Many chide oncologists for becoming "employees" but fail to recognize the personal, financial, and professional risks a growing number of our colleagues face as they are forced to close their practices, declare bankruptcy, or forgo income.

It is only natural then for these physicians to seek new arrangements that can provide market-based compensation for their unique and valuable expertise. Academics have long worked for set compensation at financially stable organizations that often have large endowments, research and support services backing, and the latest diagnostic and information technology. Although they most often work for salaries, their benefit packages are usually more substantial than those afforded to oncologists in the average small or midsized community practice. Salaries at academic institutions are often balanced by guaranteed retirement programs or high-dollar employer retirement and benefit contributions, tuition waivers or contributions for themselves and their families, sabbatical time, travel and professional development reimbursements, protected research time, and variable housing supplements and discounts. By contrast, community oncology practices have not been able to pay their physicians competitive salaries, let alone to offer them competitive compensation packages and fully funded pension contributions as reimbursements have decreased. Private practice physicians, like everyone else in the higher-income brackets, will pay almost half their income in taxes, then need to save another quarter to fund their retirement and their children's education costs. As practice revenue has plummeted, and especially in areas where there are a lot of lower-paying, risk-bearing managed-care organizations, physician compensation is no longer sufficiently competitive to attract and retain top quality oncology specialists.

Physician compensation should be a package of salary and benefits that adequately rewards the best and the brightest. Clinicians who have the peace of mind that they are being competitively compensated can focus on the lifelong demands of ongoing learning, delivering compassionate care, and investigation that cancer patients deserve.

We are hearing much about expanding hospital and health-system alignment and about more doctors choosing to forgo or leave private practice. There is concern about a return to the 1990s when hospitals bought or aligned with physician groups, only to have those arrangements disintegrate a few years later. Given the high costs of running a private

oncology practice, the inability to negotiate cost-plus-margin-plus-value–based incentives for care, and the growing inability to build value in a practice that can be sold to fund retirement as managed care organizations and health systems aggregate patients and payers, it is not likely that physicians who join hospitals or health systems will return to private practices. Although this may temporarily slow the notable innovations that oncology practices have pioneered over the years, it will bring physicians, payers, and hospitals into systems of care that will likely better serve patients in the long run. As these new business models for cancer care are being developed, physician compensation, long the "secret" no one has talked about but at which many are now taking aim, deserves to be revisited through comprehensive, evidence-based analysis. As systems compete, they will want to attract and retain the most talented physicians who can keep current in a constantly evolving field while leading a team in complex multimodality care of patients with life-threatening diseases.

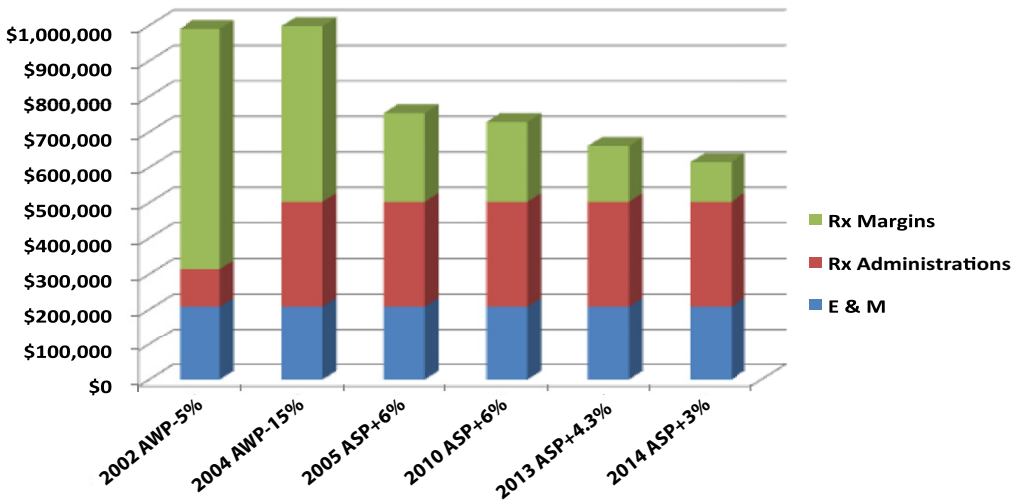

FIGURE 2 Decreasing oncology drug margins continue to compress oncologist income.
Abbreviations: ASP, average selling price; AWP, average wholesale price; E & M, evaluation and management; rx, drug(s).

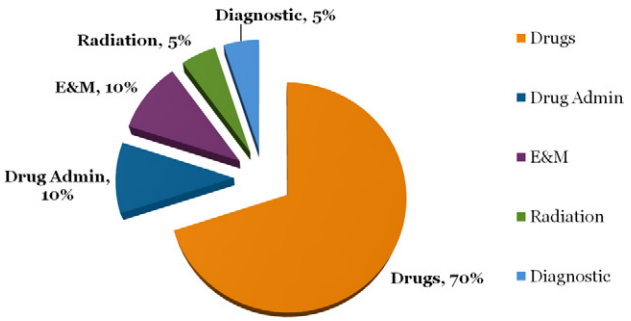

FIGURE 3 Breakdown of oncologist income by service mix. Reproduced with permission from WOMGI.
Abbreviation: E & M, evaluation and management.

We value our free-enterprise system of health care. As such, we need to recognize that value-based, integrated systems of care delivered at the site of service will drive out inefficiencies, unnecessary under- and over-treatments, and provide transparent and accountable reporting so that consumers can make informed decisions about how and where to spend their premium dollars to grow and support high-value care. The current generation of oncologists, more than half of whom are older than 60, has been caught in the transition from mom-and-pop businesses that were financially rewarding to businesses that are financially unstable. These are challenging times as we shift from volume-based care to value-based care, but as we do so, now is the right time for physician compensation to be brought to the negotiation table and afforded the same evidence-based analysis and consideration that we apply to our clinical care models. Corporate executives and business leaders have long had their lucrative and ever-growing compensation packages fully disclosed and debated by shareholders and compensation committees. Physicians should not shy away from a similar review of their value in pioneering, delivering, and leading new value-based systems of cancer care that can markedly lower the total cost of care while providing the integrated high-quality, high-touch, community-based care that patients value. When the training, experience, and ongoing demands of oncology physicians are analyzed, it is likely that compensation plans will fully validate the uniquely trained and equipped specialists we want to incentivize to deliver quality cancer care in communities and in integrated health care systems.

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