

Managing change in oncology

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As I write this, the permanent fix to the sustainable growth rate (SGR) has been passed overwhelmingly in the US House of Representatives. The Senate has adjourned for spring break so has yet to vote on the fix, but there is optimism that it will pass when the session resumes. Doctors have feared that the 21% payment reduction that would automatically be triggered if the SGR fix were not passed would result in them having to close their doors to Medicare patients. Congress has postponed the SGR cuts 17 times since 2003. The uncertainty around this legislation and the time that practicing oncologists have spent conjuring up temporary solutions since 2003 is maddening.

Estimates of the cost to pay for a permanent fix for physician payments in the SGR are between \$170-200 billion dollars over 10 years. The ways in which we will pay for this change are controversial. The pending proposal cuts some reimbursement to hospitals. Part of the “pay for” incorporates means-testing, which will necessitate that wealthier Medicare recipients pay more for their coverage.

This is a critical time to consider some macrotrends in oncology. As we look at United States Census predictions of the change over time in the age distribution of the population, we can see that the number of people over age 60 will double in the next 20 years. More than two-thirds of cancers occur in that over-60 population, and as a consequence cancer incidence will increase markedly. This will precipitate considerable workforce challenges in oncology, and even if all other factors are held constant, it will also cause substantial increases in the overall cost of cancer care in the United States. However, not all other factors are constant: innovative (read: more effective *and* more expensive) therapies continue to be approved at a rapid rate, more patients are cured of their cancers, and more patients are treated for cancers over longer periods as cancer in many instances becomes a chronic disease, with patients living a long time and often dying of

other causes. All of these favorable changes will synergistically increase the prevalence of cancer and cause further increases in cancer costs. Most of these shifts in cancer incidence, prevalence, and cost need to be managed by oncology practitioners.

While oncology practitioners face these changes, administrative burdens on quality reporting are rising concomitantly. Aside from the meaningful-use require-

ments, many practices report on quality measures to satisfy innovative payment contracts that likely will increase exponentially for the foreseeable future so that practitioners will have to manage more information on an increasing number of patients. These increasing administrative and clinical demands on the oncology practitioner in private practices add to the powerful financial pressures to affiliate with hospitals. In addition to the heightened revenue potential of the expanded 340B program for



tax-exempt qualifying hospitals and the preferential fee schedules for all hospital outpatient departments in comparison with private community oncology practices, many hospitals have the infrastructure to support the escalating workforce and administrative demands that are being placed on oncologists. In the last 5 years, hundreds of private oncology practices have closed, often to affiliate with hospital systems to help manage these financial and administrative pressures.

The natural consequences of this shift in site of service is that per patient, per episode of care cancer costs will rise because of the disparate payment systems that favor hospital outpatient departments over traditional private community practices. This increasing shift toward hospital-based services will further exacerbate the increasing cost of cancer care in the United States.

As community oncology providers, these changes will likely fundamentally change the way we deliver care. We have a lot of work to do. Thank you for all of your work to improve cancer care.