

## What's Ahead for Oncology Practices on Capitol Hill?

With health care reform a moving target for legislators and regulators in the nation's capital, community oncologists are closely watching issues that affect their practices. Here are some of the concerns and hopes for the Obama administration, as voiced at recent professional meetings.

## Rethinking the Medicare Modernization Act

BY CAROLINE HELWICK

SCOTTSDALE, ARIZ. — The 2003 Medicare Modernization Act came under fire during the annual Community Oncology Conference as a panel of lobbyists and consultants familiar with the political landscape discussed how current proposals may affect oncology.

Restoring critical aspects of Medicare reimbursement that were slashed as a result of the 2003 Medicare Modernization Act (MMA) is a fundamental need, according to these legislative round table participants who contend the cuts have limited treatment options and diminished quality of care. The specifics of such restorations amount to a lengthy list, and action on any of the proposals will not come right away, but panelists said opportunities are available to right the wrongs.

"Having a new administration and Congress gives us an opportunity to restart the conversation and correct what happened with the '03 MMA," said Martin A. Corry, director of federal health policy for the Washington law firm Buchanan Ingersoll & Rooney.

For Ted Okon, executive director of the Community Oncology Alliance (COA), the first orders of business should be the elimination of the prompt payment discount, which artificially reduces reimbursement and negatively impacts patient care, and the re-

pair of the physician fee schedule, which is scheduled to be cut in January 2010. "Patching this is likely to be out of the realm of possibility. There is a focus on actually trying to fix this," he said.

John Akscin, vice president of government relations for McKesson Specialty Care Solutions, agreed. "I don't believe that Capitol Hill will let physi-

**Proposals for competitive effectiveness will require evidence, 'and this plays to your strengths. ... Show that you use a high-cost drug because "drug X" is not working.'**

cians go into 2010 with a 21% cut," he predicted. "I think something will be done."

But Mr. Corry was more cautious. "We could still find ourselves with a temporary patch, because a full fix of the sustainable growth rate will cost about \$300 billion," he pointed out, "and other things may be viewed as more important in the context of the economy."

Because of the focus on the economic crisis, health care reform may not be accomplished in 2009, although some compo-

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### Health Reform, Fee Fix Are Looming

BY ALICIA AULT

NATIONAL HARBOR, MD.— With health reform prominently featured in President Obama's budget blueprint and congressional leaders vowing to have a plan in place to vote on by early summer, there are both opportunities and pitfalls in the year ahead for oncology practitioners.

So presaged Matthew Farber, manager of provider economics and public policy for the Association of Community Cancer Centers (ACCC), at the organization's annual meeting.

The ACCC has been working with the American Society of Clinical Oncology and other oncology groups to present a united front to Congress, said Mr. Farber. And being on the front lines of cancer care gives oncologists credibility with staffers and congressmen.

"They know we have the membership behind us and have a real-world understanding of how their policies affect patients," he said.

Nonetheless, there are areas of concern, with a top issue being the Medicare fee schedule, according to Mr. Farber.

Even though there was an overall 1.1% increase for 2009, in reality, the changes in the conversion factor led to an absolute 1% decrease for oncologists, he said. Radiation oncologists had a 3% decrease.

The sustainable growth rate will be addressed in the fall, continued Mr. Farber. Although there may be just another one-time fix—heading off a scheduled 21% cut for 2010—at least President Obama has acknowledged the true cost of such Band-Aid approaches in his fiscal 2010 proposal, he said.

Both the Obama Administration and Senate Finance Committee Chairman Sen. Max Baucus have signaled that

comparative effectiveness will be a major component of the government's attempts to rein in costs. Although legislators have been careful to say that they're not looking at cost-effectiveness, this is yet another area of concern for oncologists, said Mr. Farber.

"Cancer is a very personalized disease," he said. "What might be effective for one person might not be as effective for someone else."

The following are some other issues that the ACCC is monitoring:

► **Medicare's 2009 hospital outpatient payment rule.** Changes in reimbursement for chemotherapy meant that, often, Medicare's contractors aren't reimbursing for intravenous antiemetics. The ACCC has been pushing for changes to that policy.

The organization is also talking to the Centers for Medicare and Medicaid Services about the requirement that physicians be present during therapeutic procedures. Many providers aren't aware that they need to comply with this rule, said Mr. Farber.

► **The 21st Century Cancer ALERT (Access to Life-Saving Early Detection, Research and Treatment) Act (S. 717).** This legislation, which is sponsored by Sen. Edward Kennedy (D-Mass.) and Sen. Kay Bailey Hutchison (R-Tex.), was reintroduced in late March and would provide more funding for prevention, research, and guidelines.

► **E-prescribing.** Although bonuses for using e-prescribing are on the table now, penalties for not having the system will come soon enough. And there are still many bugs in the system, said Mr. Farber.

► **The Physician Quality Reporting Initiative (PQRI).** Many participants did not receive their bonuses this year, nor did they get a good explanation from CMS of what they had done incorrectly, he said.

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nents of Medicare reform will be realized, Mr. Okon said.

"There are huge forces at play, and there is a drive to accomplish something this year, but the urgency of the stimulus plan and seeing former Sen. [Tom] Daschle eliminated [as a candidate for Health and Human Services secretary] may mean this will occur next year instead," he offered.

Meanwhile, the stimulus package includes \$19 billion for health information technology (HIT), with incentives of \$40,000-\$60,000 per physician. HIT is an Obama administration priority, but it's still not clear exactly how the stimulus money will be spent.

Panelists foresaw "robust" activity for payment rules that include such concepts as service bundling, value-based purchasing, and competitive effectiveness, which could create funda-

mental shifts in reimbursements, panelists said. Although comparative effectiveness could be a good thing, it might allow government to "trump" oncologists' decisions, Mr. Okon warned.

Rational proposals regarding competitive effectiveness will require evidence, "and this plays to your strengths," Mr. Corry told oncologists and administrators. "That is, show that you use a high-cost drug because 'drug X' is not working." Panelists agreed that lawmakers need hard data from oncologists in practice in order to make good decisions.

Competitive effectiveness is part of the government's goal of moving away from quantity-based payment in favor of quality-based payment. "We are moving from pay-for-reporting to looking at process measures, and will eventually move toward real measures of quality and outcomes,

but we are not there yet," Mr. Corry said. "In the meantime, it is important that oncologists keep talking to [the Centers for Medicare and Medicaid Services] and Congress about making

the mechanisms work in the real world."

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### Medicare Part B Fix

The Community Oncology Alliance issued a resolution urging Congress and the Obama administration to restore critical aspects of Medicare Part B reimbursement stemming from the MMA.

Key aspects of the resolution call for the government to do the following:

- ▶ Eliminate the inclusion of the prompt payment discount from the calculation of average sales price (ASP), which reduces the Medicare drug reimbursement as well as private payer reimbursements that are

based on ASP.

- ▶ Establish appropriate payment for essential cancer care services (such as treatment planning, or maintaining pharmacy facilities) for which Medicare does not pay and which are not reimbursed by private payers following the Medicare system.

- ▶ Establish appropriate payment for cancer drug administration.

- ▶ Provide relief for patients with inadequate secondary insurance to cover the Medicare 20% copay requirement.

## Cutting the Cost of Cancer Care: Payers Consider Novel Options

BY CAROLINE HELWICK

SCOTTSDALE, ARIZ. — Measures that might reduce the cost of oncology care without compromising patient care are under discussion but are far from being adopted, according to panelists who discussed payment issues at the annual Community Oncology Conference.

"The Wall Street scenario is about to be repeated in the health care arena, and there is a sense of urgency," said Dr. Lee N. Newcomer, senior vice president of UnitedHealthcare Oncology Services.

Medicare reimbursement covers 80% of the cost of inpatient care, and this type of fiscal shortfall could presage the collapse of hospital systems, he said. "As hospital systems start collapsing, the situation will look like the housing crisis. We are spending a trillion dollars on the banking industry. Will there be a trillion left for health care?"

The United States has the world's highest per capita spending on health care, but the amount spent has had little to no effect on life expectancy, said Dr. William D. Rogers, director of the Physician Regulatory Issues Team at the Centers for Medicare and Medicaid Services. Higher spending does not lead to higher quality of care, he noted.

The trend is for greater cost sharing, with more expenses being shifted to

the patient, "although health care will remain a shared responsibility," said Dr. Burton F. VanderLaan, regional medical director of Aetna Inc.

Physicians and patients are factoring in cost when making treatment decisions, Dr. VanderLaan said. A recent Thomson Reuters survey found that 12% of cancer patients declined care because of financial constraints. And in a 2008 survey of oncologists, 39% said that financial factors shaped their presentation of treatment options, and



**'The cost crisis is driving a fundamental change in the practice of oncology.'**

**Dr. VanderLaan**

57% said patients' out-of-pocket costs forced more candid descriptions of treatment benefits.

"In other words, the cost crisis is driving a fundamental change in the practice of oncology," he said.

Private payers are devising their own approaches to managing costs, whereas the federal government manages the problem by simply lowering reimbursements, Dr. Newcomer said.

But Medicare's hands are essentially tied without congressional action. "We pay per visit, and we have no flex-

ibility in this," Dr. Rogers said.

In the private sector, one proposed model is the pathway-driven oncology management program, which theoretically might save money by reducing variation, ensuring the use of cost-efficient treatments, limiting off-label use of drugs, reducing cycles of drug treatment, preventing medical errors, and requiring outcomes reporting, according to Dr. VanderLaan. But Aetna "has looked skeptically upon these programs," he said.

UnitedHealthcare is evaluating the "episode of care" payment model in a pilot program. Under this model, oncologists would receive a lump sum payment that covers all aspects of the patient's needs based on disease stage and status. The program would not pay separately for the administration of drugs.

"You will get a single check on day 1. True, this is radically different," Dr. Newcomer acknowledged, "but if we don't change things radically, I think we are going down the tubes."

Data are needed to demonstrate which approaches work and which do not, emphasized Dr. Linda Bosserman of an oncology group practice in Los Angeles. "There is a need for clinical information to be provided to decision makers" who evaluate what is new and what has value, she said.

Audience member Dr. Carey A. Preasant, past president of the Association of Community Cancer Centers,

agreed that different models of care should be formally evaluated in trials with clinical, utilization, and quality-of-care end points.

"The health care reform requirements are now based on no data. I am surprised that third-party payers have not embraced trials and demonstration projects as a way to evaluate different processes," he told the panel.

There is also a lack of clear dialogue among parties, according to Dawn G. Holcombe, a consultant and executive director of the Connecticut Oncology Association, Hartford. "It has gotten harder to talk to people outside our own silos because the oncology world has different languages," she said.

"The interpretation of 'appropriate care,' 'value,' and 'medical necessity,' for example, differs between the clinical and the payer worlds. These need clarification when we start conversations."

"The fundamentally flawed approach that providers have been taking is, 'We provide a great thing. Our health care is better [in the United States] than elsewhere. And all we need is a little more money to meet our costs and build our practices.' Those days are over," Dr. Rogers said, warning, "It is just not affordable to continue to do things [as we] are doing them now."

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