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Editorial

The Changing Face of Community Practice: The New Normal

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I think it started in 2004. I happened to be President of ASCO at the time and we had a crisis: the Medicare Modernization Act. Cuts in reimbursement for drugs threatened the financial stability of community oncologists around the country. It was a hard fight. We received some concessions, but these did not last long and, over time, this revenue stream has eroded further. Small community practices are disappearing as oncologists flee to the shelter of facility-based practices, primarily hospitals, or large HMOs, or merge practices with large groups, such as US Oncology Network. This doesn't help the cost of health care, since studies show that care in facility-based practices is actually more expensive.

Understanding how we got into this pickle is relatively easy. In the 1980s, use of outpatient chemotherapy became more prevalent, and the system allowed practices to buy drugs and essentially sell them as part of care. This became lucrative. The revenue stream allowed for "concierge care" for everyone at the community level by covering the overhead of nurses, nurse navigators, medical assistants, physician extenders, and so on. It was a good deal and no one wanted to break a system that worked. But during this time, we lost opportunities for reimbursement reform. Medicine in this country is still a fee-for-service business. We only really get paid for tests and procedures, not for triage management, counselling, phone calls, and e-mails.

Nor does this just affect oncologists: in a recent editorial in *The New York Times*, Elizabeth Rosenthal wrote that 60% of physician job placements through Merritt Hawkins & Associates, a leading physician placement firm, were for salaried positions, compared with 11% 10 years ago.[1] In the San Francisco Bay Area, where I practice, pediatricians, family medicine doctors, and general internists earn about the same salary as nurses. Since they are trying to survive solely on "evaluation and management" code reimbursement, there is little left for overhead to support office staff.

I used to support reimbursement reform. I guess I still do, but oncologists are not going to come back to community practice as it was before. Those days are over. That said, for large practices that remain, a "chemotherapy management" code would go a long way to help balance the books. And what about the Affordable Care Act? I don't think any of us understand yet how this will impact us, but my crystal ball suggests more emphasis on quality metrics and an increased emphasis on global case rates. Management of a given diagnosis will earn a lump sum, and it will be up to us to decide how to stay within "budget" for a given patient's episode of care.

Frankly, it's a brave new world. Scientifically, it's never been more exciting. The emergence of biomarkers for use in precision medicine or as surrogates for outcome will improve care, but will also help control overall cost. The NCCN Guidelines will become increasingly important as guidance for payers and determinants of cost of care. Evidence-based medicine will always remain best practice, but defining best of care for increasingly small subsets based on molecular, not clinical, findings will be a challenge.

As for the business of medical oncology, I think it's time to embrace the "new normal" and be proactive in finding a future with better, more cost-effective care and a sustainable business plan to support it. We can do this.

Reference

1. Rosenthal E. Apprehensive, many doctors shift to jobs with salaries. The New York Times. February 13, 2014. Available at: http://www.nytimes.com/2014/02/14/us/salaried-doctors-may-not-lead-to-cheaperhealth-care.html?ref=elisabethrosenthal&_r=0. Accessed March 21, 2014.

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