

Community Oncology Alliance

Dedicated to high quality, affordable, and accessible cancer care

1101 Pennsylvania Ave., NW
Suite 700
Washington, DC 20004
(202) 756-2258
communityoncology.org

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To All in Community Oncology:

I would like to thank the Board of Directors of the Community Oncology Alliance (COA) for electing me as the next President. I have been very fortunate to be able to participate in the development of COA over the past few years. During this time it has become a leading organization dedicated to supporting community oncology practices in fulfilling their mission of providing high quality, affordable cancer care in local communities. Much of the success of COA has come from the excellent leadership of past Presidents. I would especially like to recognize Dr. Patrick Cobb, who agreed to extend his term during the final stages of health care reform legislation. Dr. Cobb's policy knowledge and work on Capitol Hill was instrumental in representing community oncology during the health care reform debate. The Patient Protection and Affordable Care Act will certainly reshape the landscape of medicine in general and oncology in particular. It is in this context that I begin my term as COA President.

While health care reform law contains many positive provisions, such as elimination of pre-existing conditions, the potential negative consequences for cancer care need to be recognized. Massachusetts enacted statewide healthcare reform legislation several years ago that is similar to the new federal law. Massachusetts is having great difficulty affording the expanded coverage provided by its plan and is now actively exploring capitation measures, such as paying for episodes of care rather than the more traditional fee for service model. These types of capitation models are included as demonstration projects in the federal healthcare reform law. Given the contentious national debate over health care reform and the gradual implementation of many provisions, I believe we can expect continued modifications to the law. Already there is discussion of legislation to provide technical corrections to the law.

How will private community oncology clinics fare in this changing landscape? Unfortunately, I am concerned that without positive change, practices may not do very well. Healthcare reform does little to solve the current challenges faced by community oncology practices. Previous legislation, such as the Medicare Modernization Act (MMA), and CMS reductions in payments for infusion services have already pushed many practices beyond the point of viability.

COA has maintained the position that previous reform of the payment system for oncology has never accurately identified the true cost of providing cancer care. The modest payment increases for cancer care services, such as infusions, did not offset the decrease in drug reimbursement mandated by the MMA. The current failure of community practices to continue their operations is evidence of these facts. Also problematic, I believe that many practices are turning to the hospital model with limited understanding of potential pitfalls. Currently, some hospitals receive a subsidy under the 340b program, which allows them to purchase drugs at discounts not available to other providers. The discounts are proportional to the amount of indigent care provided by the hospital. Under healthcare reform, the proportion of uninsured patients will decline over time, which will impede 340b programs. Physicians may be joining hospitals with salary contracts subsidized by 340b drug pricing, which may not be available when their current contracts require renewal.

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How will patients battling cancer do as health care reform unfolds? Clearly, the new law makes important improvements, including the elimination of pre-existing conditions, the elimination of lifetime and annual payment caps, and expanding the Medicaid program to all Americans with income up to 133% of the federal poverty level. Additionally, ensuring that private insurance companies cannot prohibit cancer patients from participating in clinical trials and requiring payers to cover the routine costs of care is an important plus for cancer patients.

Despite these improvements, many glaring problems remain. Oncology patients who have Medicare coverage without the support of a secondary insurance plan will continue to face a prohibitive 20% co-payment for oncology drugs. This excessive cost burden on patients often renders standard of care treatment unaffordable. Many patients in rural areas are finding that their community cancer clinic is closing its doors necessitating long distance travel for care. Those of us who care for fragile oncology patients understand how this increases the risk for adverse outcomes. Additionally, pervasive obstacles for oncologists eventually impair access for patients. According to published estimates, one out of four cancer patients will be short an oncologist by 2020. Currently, the United States has the best overall cancer survival rates in the world. I believe much of this improved survival is due to greater availability of screening, diagnostic testing, and effective treatments provided by skilled and concerned physicians in local communities. The success of our nation's cancer care delivery is now at risk.

What can COA do to mitigate these challenges for practices and patients? First and foremost, COA can proudly defend the value of community cancer centers. Greater than 80% of cancer patients in the United States are cared for in community cancer centers. We can certainly share in the credit for having the highest cancer survival rates in the world. Proposed changes in the cancer delivery system should be rigorously scrutinized before putting this national success story at risk. Much of the debate about improving quality is just a thinly veiled argument about cost. We need to draw attention to this.

On a policy front, COA fought hard to stop the severe Medicare payment cuts to oncology-specific services scheduled for 2010. Practices all across the country reached out to their members of Congress to join in a letter campaign to stop these cuts. I was especially proud of the cancer community in my state, North Carolina, which was successful in getting every Representative to join in this campaign. Very significantly, COA worked with Congress in crafting the *National Quality Cancer Care Demonstration Project Act* (H.R. 3675), the concept for which we fought to get in the health care reform under the new CMS *Medicare Innovation Center*. This will provide additional funding to practices for demonstrating quality treatment planning, adherence to guidelines, and survivorship planning. We have recently created an Imaging and Radiation Committee to help shape the debate regarding the appropriate use of diagnostic imaging and radiation therapy in oncology practices. Additionally, COA has a public relations firm that is proactively engaged in the national media debate over oncology care and has been instrumental in dispelling much of the misinformation surrounding the provision of high quality cancer care. Finally, we will maintain persistent lobbying efforts on Capitol Hill and continue to argue that the inclusion of the prompt pay discount between manufacturers and distributors in the calculation of average sales price (ASP) is inappropriate and harmful to community oncology clinics.

Beyond this, COA has been extremely active with multiple projects that study various aspects of our cancer delivery system. We have done this so that policy


makers can better understand the true resources required to deliver high quality oncology care. We recently completed our *Components of Care* study, which systematically analyzed the activities and cost structure behind delivering cancer care to Medicare beneficiaries. The study found that in 2008, Medicare payments for infusion services covered only 57% of the true cost of providing care.

Unfortunately, Medicare payments for infusion services will continue to decline through 2013. COA also continues to work on the *Orals Study*, which demonstrates the significant barriers that patients face paying for and obtaining vital oral cancer therapeutics. We have developed the *COA Administrators' Network* to help ensure all practices can have the most up to date information on the spectrum of practice management issues so they may operate efficiently and maintain viability. Our new *COA Patient Advocacy Network* gives voice to the most important group, patients who are battling or have battled cancer. No group better understands the value of high quality care.

What can practices do to help shape their own future instead of having it handed to them? Simply deciding to work harder in one's own silo will not be effective. The current problems are too great. As experts in the delivery of cancer care, we need to all work collaboratively to innovate and reshape the future of our specialty. All oncologists should now feel the responsibility to speak out and engage in our national debate. Leaving this effort to only a few will only weaken our profession. Despite much of the noise that creates confusion in oncology policy debates, many of the current problems can be distilled down to one element; cost. There is no doubt that we provide tremendous value to our patients but the future will demand that we do so at lower aggregate cost. Innovations such as clinical pathways may help with this effort and practicing oncologists need to lead the way.

Please join with COA as we move forward to tackle these challenges. All of us need to move quickly and proactively or we will only have larger problems to solve in the future. Remember that you are the expert, the person who saves lives, and the person who really understands how cancer care is delivered. Your voice needs to be heard.

Sincerely,

A handwritten signature in black ink that reads "David Eagle M.D." in a cursive style.

David Eagle, MD
President