

## The Dinosaur Is Extinct: The Demise of Solo Medical Oncology Practice in the United States

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Five years ago, I had the honor of contributing one of the first original articles to *Journal of Oncology Practice*: "The Dinosaur Lives: How a Solo Medical Oncology Practice Survives."<sup>1</sup> Today, I have the obligation of writing the sequel. I am not proud of this piece, and all else being equal, I would have preferred not to write it, but it is a story that must be told. In the interest of being green, rather than reiterate here the points of the original article, I ask the reader to refer to it for the principles of sound practice management, which are as applicable today as they were then.

Sometimes evolution is brought about by subtle genetic and environmental pressures over long periods of time, allowing for a species to slowly adapt to change. Other times, evolution is brought about by a cataclysmic extinction event. The latter is the case for the solo medical oncologist, and the event was the Medicare Modernization Act of 2003 (MMA 2003).<sup>2</sup> For more than 15 years before 2003, the payment method in place for reimbursement for chemotherapy services and drugs for Medicare beneficiaries, although not perfect by any means, worked to keep medical oncology practitioners financially whole and in the business of providing high-quality cancer care to our patients. However, after the push of some voting buttons and stroke of a pen, the reimbursement changes in MMA 2003 started the dismantling of the means by which cancer care is provided in communities across the country. The provisions in MMA 2003 specifically related to cancer care were promoted by a small number of partisan politicians whose only concern was their personal agenda, not the good of their constituents. They did not understand or chose to ignore the pleas of thousands of physicians and tens of thousands of patients regarding the consequences of their actions. Even today, Congress remains paralyzed by partisan politics, with seemingly no concern for the welfare of the people of this nation.

From 2004 to 2006, various oncology-specific demonstration projects provided some extra revenue to help us in transition, but by the end of 2007 and early 2008, the full impact of MMA 2003 was realized. Any profit on chemotherapy drugs and biologicals simply disappeared. Margins of 2% to 3% on some drugs were negated by other drugs being underwater, and some drugs were reimbursed at a rate lower than the acquisition cost for many practices in any given quarter. As practice managers, we were expected to manage a \$2 million capital expense with virtually no net margin at all. Although payments for chemotherapy administration services were increased by MMA 2003, those monies were inadequate to keep up with the in-

creasing cost of goods and services. For me, 2008 became the perfect storm.

Anticipating practice growth and positioning myself for the future, I incurred considerable capital expense in upgrading our computer system, updating medical equipment, expanding the office to ultimately accommodate another physician or midlevel practitioner, and generally improving practice efficiency. Those funds came from my personal portfolio as a loan to the practice. At the same time, our margin continued to slowly decline. We were no longer able to take time off except for weekends; overhead expenses were just too great. The increased use of expensive drugs only added to our cash flow burden and risk. Our hospital nurses unionized, and we were faced with paying much higher salaries and benefits to retain high-quality infusion nurses. Revenue from the use of erythropoiesis-stimulating agents disappeared. I garnered a major new referral source for patients with breast cancer, which resulted in a shift in our payer mix from predominately Medicare to a commercial carrier with a notorious and nefarious reputation in California. I suddenly had a large number of patients receiving long-term Herceptin (trastuzumab; Genentech, South San Francisco, CA), and this particular carrier had the habit of paying for inexpensive chemotherapy drugs and administration while holding up payment for trastuzumab for 2 to 3 months for so-called medical review. Remember the phrase "authorization for treatment does not guarantee payment"? Certainly not timely payment. Then came the great recession. My portfolio tanked, patients could no longer make their copayments, and creditors tightened up on lending; the list went on.

By early 2009, it was apparent that we were headed for bankruptcy. Our hospital was not in a position to help. In California, hospitals are prevented by law from employing physicians. Our particular hospital was just emerging from 4 years of administrative disarray and was fighting to survive. After great soul searching, my wife and I realized that our only option was to close the practice; sell our home to start to pay down debt; and move on to join a hospital-affiliated practice, enter academic medicine, or join a large oncology group. Our search lasted several months, and we met wonderful people along the way. To the readers of this missive who welcomed us into their communities, homes, and practices across the country, we are deeply appreciative. We landed in the Puget Sound area just south of Seattle. I joined a group with five medical oncologists, two radiation oncologists, and two midlevel practitioners. I am now the medical director of a new comprehensive cancer center, the third clinic site for the practice. We have fully integrated