

Commentary

Medicare reform is shutting patients out

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Never before in 30 years of serving as a medical administrator have I had to determine, based on reimbursement, who we could treat and who we could not. Today, the elderly patient on Medicare has to be triaged according to their ability to pay. Cancer care is becoming a privilege in our society. Speaking as one who has been affected by cancer, I find this upsetting.”

That is just one of the many similar letters we have received at The Community Oncology Alliance in response to a survey we disseminated to practices around the country asking about the effect of the most recent cuts to Medicare reimbursement. As of press time, 69 community oncology practices from 27 states had reported serious problems with patient access to care. Overall, practices told us that the Medicare cuts have forced them to turn away new Medicare patients, send more patients to hospitals for treatment, or close treatment facilities. Problems implementing Medicare Part D are adding to the burden.

Practices report spending an excessive amount of time on adminis-

tration, especially relating to precertification of treatment. Because an increasing number of private insurers are adopting the new Medicare reimbursement system, practices are now forced to deal with these changes as well. With staff paying more attention to financial issues, the Medicare changes are actually detracting from patient care.

Why is this happening?

Medicare reimbursement for treatment regimens has declined by double digits since 2003. Most practices now report that their Medicare “book of business” is reimbursed substantially below cost. As the first quarter of 2006 closes, many practices will undoubtedly realize just how much lower reimbursement receipts are in 2006 as compared with 2005. And as 2006 unfolds, we expect to see a spike in the number of problems reported relating to access to cancer care. The upshot is a shift in care to other, more costly, settings such as the hospital.

Based on the input we have received from community oncology practices thus far, the 2006 demonstration project implemented by the Centers for Medicare & Medicaid Services is reimbursing practices only

about 35% of the payments provided by the 2005 project. This is the equivalent of an estimated \$200 million cut from Medicare funding for cancer care. Although it appears at the time this update was written that the scheduled 4.4% cut in physicians’ fee payments will be not implemented in 2006, we do know that the 3% transitional increase for cancer drug administration has been eliminated. Exacerbating the impact of these cuts is the fact that bad debt—conservatively, an estimated 5%—continues to be a reality faced by community oncology practices.

Reform or deform?

All of these cuts come at a time of significant medical inflation—close to 4% per year. Many of the cancer regimens used to treat Medicare patients are now being reimbursed, not only less than the underlying cost of drugs, but below cost of the materials and human resources as well.

Of course, of paramount concern is the human cost to patients. What happens to them when the network of community practices frays and breaks? We have to ask our policy makers: Are we reforming the delivery of cancer care in this country? Or deforming it beyond recognition?