The Waiting Game

What will the new Medicare drug payments do to patient access to care?

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In 2004 we in the oncology community face a year of uncertainty as we wait for the Centers for Medicare & Medicaid Services (CMS) to determine the average sales price (ASP) of cancer drugs, and then face the consequences of how this new reimbursement methodology will impact medical oncologists and the delivery of cancer care. I have been working in oncology for more than 24 years and consider this year to be one of the most perilous ones for medical oncologists and the patients and families that they serve.

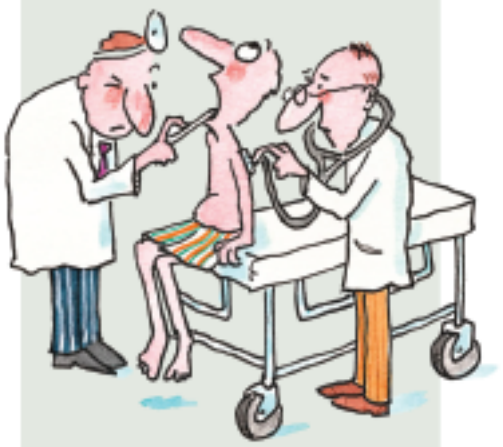
At ACCC's Annual Meeting last March in Washington D.C., I had the opportunity to meet an office manager and an oncology clinical nurse specialist from a rural medical oncology practice. We talked about the potential impact of the new Medicare drug payment plan on medical oncology practices in rural settings. This oncology practice provides care in a rural area that is two to three hours from any large city where patients can access comprehensive cancer care. They explained that the small local hospital in this area does not provide radiation oncology, and as a result, many of the patients do not have an option for radiation therapy, only chemotherapy. While this practice has been slowly growing, it faces a year of uncertainty. Depending on how the new Medicare drug reimbursement methodology is structured, the oncologist who works at this practice may end up opting out of practicing medical oncology altogether. If this practice closes, patients in this rural area will have only one option—driving two to three hours for medical oncology and radiation oncology treatments.

By contrast, I live in the Chicago market. Here, a comprehensive oncology program can be found every 10 miles. Needless to say, patient access to cancer care services is not a problem. But as I talked with these new colleagues from a vastly different healthcare setting, I was reminded of the reality for patients in rural areas. If local medical oncology practices close—access to care will be curtailed. Many patients will not be able to handle a two-to-three-hour commute for care. They also may not have the financial resources to stay overnight for tests and treatments. The staff at this rural oncology practice indicated that they treat a number of patients who are not eligible for Medicaid and are relying on free pharmaceutical drug programs.

So, we wait to learn how the ASP methodology will work. For some medical oncologists, the result may be a decision to leave oncology care. If this happens, it saddens me to know that there will be patients in this country who will not have accessible and adequate cancer care.

We won't know what the final ASP reimbursement structure will look like for several months. In the meantime, we oncology professionals need to be prepared, and we need to make immediate plans to ensure that our patients will continue to receive accessible oncology care.

ACCC is diligently working with CMS and keeping abreast of the situation. Our membership will be notified of the new regulations and how they will impact physicians, hospitals, and our patients and their families. Until then, community cancer centers continue to work hard to ensure patients quality cancer care close to home.



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