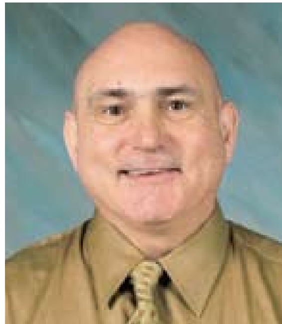
Cut to the Bone

by James C. Chingos, MD, CPE

From my perspective, our nation as a whole and our patients with cancer, in particular, stand at the threshold of an access problem that will be a "double cross" to our burgeoning elderly population and an embarrassment to our country's healthcare system. As the cliché goes, "you don't have to be a rocket scientist" to figure out that if CMS continues to decrease the reimbursement for outpatient cancer services in the community setting to the point where no financial incentive to perform the service exists, then the service will no longer continue. Who in their right mind would run a business in which a significant portion—as well as a continually growing portion—of the clientele equate to a zero gain or loss of revenue? When it is no longer feasible for a practice to stay in business, when close-to-home quality care is no longer an option, the community it serves loses as well.



As payment cuts continue, the obvious response from these practices will be either to limit the percentage of that population in the practice or simply to eliminate it entirely (i.e., refuse to accept this clientele).

And yet, by all projections, this is the clientele—patients aged 65 and older—who will continue to increase in numbers and the need for care. By the year 2010, Medicare is expected to have enrolled approximately 46 million beneficiaries.

So while the population of older Americans continues to swell as the baby boomers age. The question is: Where will these patients go for their cancer care? The answer is obvious. If care in community settings becomes increasingly scarce, these older citizens will be sent to hospital-based settings—larger comprehensive cancer centers where feasible—or, they simply won't have access to care.

Those of us in the oncology community are well aware that access to care is a critical issue for the nation's older citizens. Already we are seeing examples of patients with cancer facing the burden of coping with geographic logistics to access care and hospital programs struggling with capacity availability while desperately attempting to survive economically. And, we are seeing a large number of the elderly poor being turned away. Again, it doesn't take a rocket scientist to see what's wrong with this picture: Everything!

On the one hand, the oncology community can take great pride in the advances in care that have been achieved over the past several decades. Our country offers the greatest and most rapidly advancing technology for the diagnosis and treatment of cancer. Each day we learn more in our fight against this disease, and our nation has a proud history of accomplishment in the arena of advancing medical knowledge. At the same time, we are witness to a regression in access to care, in which our country is slipping into a third world reality of access to care for those who are "left behind."

When all is said and done, our legislators and our regulators need to ask of themselves: *At what point does fiscal prudence set the stage for legally sanctioned socio-economic discrimination?*

And the cuts just keep coming.

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