Sequestration 'trickle-down' closes in on community practices

The effects of sequestration-related cuts on oncology practices have kicked in. In early April, Sarah Kliff, a blogger at *The Washington Post*, reported that cancer clinics had already started turning away Medicare patients because the funding cuts would make it impossible for them to continue treating their chemotherapy patients and avoid financial ruin.[1] In early May, a month after the April 1 cuts took effect, we already had 2 separate survey reports, one from the American Society of Clinical Oncology (ASCO), the other from the Community Oncology Alliance (COA), that showed that the 2% cut in Medicare reimbursement had caused oncology practices "to make significant shifts in how they do business and care for patients."[2]

ASCO surveyed 500 of its members (41% in suburban settings; 41%, in urban; 16%, in rural). In all, 80% of respondents said sequestration was affecting their practices, and about 75% said they were having trouble paying for chemotherapy drugs. Half of the respondents said they could care only for patients who had other sources of income independent of Medicare, 14% had stopped seeing Medicare patients, and half said they were sending their Medicare patients to outpatient infusion centers for their chemotherapy. ASCO president Sandra Swain expressed concern that some patients' care was being disrupted and compromised, which could be detrimental to the clinical outcomes and emotional well-being of these fragile individuals, and she warned in a statement that the society's initial findings "may just be the tip of the iceberg."[3] The fact that a quarter of respondents reported that they were planning to close satellite clinics should also raise concerns about the impact such closures might have on research and participation in clinical trials.

Findings in the second survey,[4] of 326 practice-based members of the Community Oncology Alliance, highlighted the financial challenges and risks that many already beleaguered practices have been exposed to as a result of sequestration: a third of respondents said there'd been staff layoffs or reduced staff hours at their clinics, and 21% said they were in merger talks with a hospital or were looking into ways to collaborate with other professionals.[1] (It is important to remember here that hospital mergers can result in an increase in the cost of care to patients.) Moreover, more than half of the respondents said they have had to field patient complaints about increases in the cost of drugs and the inconvenience and additional cost burden of having to travel to other venues for treatment, while a third said that facilities to which they'd referred patients had informed them that they could not handle the additional patients. As with the ASCO respondents, about half of the COA respondents said they were treating only Medicare patients who had supplemental insurance. A third said they would not treat a Medicare patients if the cost of a drug higher than what Medicare would pay for the drug.

Both groups are working to get the sequestration repealed, and the entire oncology community is backing The Cancer Patient Protect Act that would repeal the 2% cut for oncology drugs and restore any payments that were lost due to the sequestration.[1] As responsible citizens of the country, it is important for us to be sensitive about the financial challenges of our times. But when it is affecting the care of the most vulnerable members of our society, it raises many ethical questions. Is it fair to ask our patients who are already facing a life or death crisis to literally pay the price for the financial irresponsibility of the few who led us into this chaos?

Angelina Jolie's decision to undergo bilateral prophylactic mastectomy because she is a BRCA1-mutation carrier and her very thoughtful op-ed in the *New York Times*[5] has again brought the

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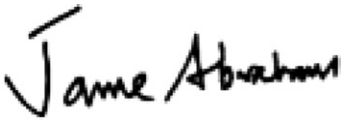
important topic of breast cancer prevention to the forefront of public debate. On page 147 of this issue, Pal and colleagues describe the intricacies and challenges that a community oncology practice faces as it tries to incorporate genetic counseling and testing into practice routine. The authors touch on the many issues that most community-based practices face in their attempts to address genetic testing, including the need for qualified, well-trained genetic counselors, the selection of appropriate patients for testing, how to deal with the immense pressure from companies that offer the testing through direct-to-consumer marketing, and ensuring that proper steps are taken in managing patients who have the BRCA mutation.

With the availability of oral anticancer agents, adherence to therapy becomes the cornerstone of successful treatment of many patients. Lack of adherence depends on many issues, including the cost of the drug, its side effects, and the patient's personal and familial circumstances. On page 138 of this issue, Welch and colleagues highlight the role of midlevel providers and nurses in working with patients to improve adherence to medication. This is highly relevant for both academic and community practices.

Finally, if you want to catch up on the excellent presentations from the 2013 Oncology Practice Summit, the annual conference hosted by COMMUNITY ONCOLOGY and its sister publications, THE JOURNAL OF SUPPORTIVE ONCOLOGY and THE ONCOLOGY REPORT, check out the last page of this issue for a 3 video interviews from the meeting. Scan the QR codes to hear a meeting round-up by Editor in Chief David Henry and Editor Linda Bosserman or for interviews with presenters Ezra Cohen on the HPV epidemic and head and neck cancer and Nicholas Vogelzang on treatment options for patients with metastatic prostate cancer.



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To listen to David Henry's podcast on bosutinib in previously treated CML and recent advances in the management of advanced NSCLC, scan the accompanying QR code or visit the COMMUNITY ONCOLOGY site at http://www.oncologypractice.com/communityoncology/ and click on the "Podcast" tab.