Medicare Modernization Act not associated with major changes in access to chemotherapy

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Despite concerns that reductions in physician reimbursements for outpatient chemotherapy related drugs as a result of the Medicare Modernization Act of 2003 would have a detrimental effect on patients requiring chemotherapy, new research indicates that there have not been major changes in travel distance and patient wait times for chemotherapy in the Medicare population since 2003, according to a study in the July 9 issue of *JAMA*.

In addition to establishing an outpatient prescription drug benefit for Medicare beneficiaries, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) changed physician reimbursement for chemotherapy-related drugs and administration services. Before the enactment of the MMA, Medicare reimbursement to physicians for chemotherapy drugs often exceeded acquisition costs because many physicians obtained the drugs at substantially discounted prices. In an effort to curtail this overpayment and align reimbursement more closely with market prices, the MMA reduced payments for chemotherapy drugs, according to background information in the article.

"… there was concern that the reduction in physician reimbursement would lead to closures of some private oncology practices, requiring the 80 percent of cancer patients who receive treatment in community settings to travel farther from their homes to local hospitals for treatment. Moreover, without sufficient opportunity to plan and expand their services and without financial incentive to do so, hospital-based clinics might not have adequate resources to support the anticipated rapid influx of patients seeking chemotherapy, thereby further delaying provision of care," the authors write.

Alisa M. Shea, M.P.H., of Duke University School of Medicine, Durham, N.C., and colleagues examined patient wait times and travel distance for chemotherapy before and after the enactment of the MMA by conducting an analysis of a nationally representative 5 percent sample of claims from the Centers for Medicare & Medicaid Services for the period 2003 through 2006. Patients were Medicare beneficiaries with new breast cancer, colorectal cancer, leukemia, lung cancer, or lymphoma who received chemotherapy in inpatient hospital, institutional outpatient, or physician office settings. In this sample, there were 5,082 new cases of breast cancer, colorectal cancer, leukemia, lung cancer, or lymphoma in 2003; 5,379 cases in 2004; 5,116 cases in 2005; and 5,288 cases in 2006.

In each year, approximately 70 percent of patients had their first chemotherapy visit in a physician office, and no more than 10 percent received chemotherapy in an inpatient hospital setting. The distribution of treatment settings in 2003 was not significantly different from 2004; however, there was a small but significant difference between 2003 and 2006. The proportion of patients receiving chemotherapy in inpatient settings decreased from 10.2 percent in 2003 to 8.8 percent in 2006, and the proportion of patients in institutional outpatient settings increased from 21.1 percent to 22.5 percent. The proportion of patients in physician offices remained at 68.7 percent.

The median (midpoint) time from diagnosis to initial chemotherapy visit was 28 days in 2003, 27 days in 2004, 29 days in 2005, and 28 days in 2006. Average wait times for chemotherapy were 1.96 days longer in 2005 than in 2003 but not significantly different in 2006 (0.88 days). Median travel distance was 7 miles in 2003 and 8 miles in 2004 through 2006. After adjustment, average travel distance remained slightly longer in 2004 (1.47 miles), 2005 (1.19 miles), and 2006 (1.30

miles) compared with 2003.

"As measured by travel distance and time to chemotherapy, our findings do not support anecdotal reports that the enactment of the MMA has changed access to chemotherapy in a meaningful way. Given the slow transition to full implementation of the reimbursement changes mandated by the MMA and the limited amount of follow-up data available at present, it may be premature to observe a relationship between these changes and delivery of care. With the aging of the U.S. population, the number of elderly individuals with cancer is expected to increase proportionally, with incidence doubling in less than 30 years. As the burden increases, researchers should continue to monitor the effects of major policy changes on Medicare beneficiaries' access to care," the authors conclude.

Source: JAMA and Archives Journals