Obama's Sequester Cuts Medicare Chemo; Cancer Clinics Appeal to Congress

by Marcia Merry Baker

April 8—Cancellation of cancer treatment and chaos are now hitting throughout the U.S. chemotherapy delivery system, under the immediate impact of April sequestration cuts to Medicare reimbursements to oncology centers, But the cuts are in accordance with the intent of the Obama Administration all along, to cut medical services, thus furthering London-prescribed depopulation, in the name of "balancing out" scarce resources.

Remember: The sequester formula was President Obama's idea back in August 2011. Its purpose was to force murderous austerity, and that's precisely what is happening.

The set-up for this begins with the fact that four out of five U.S. cancer patients are treated in the clinic setting, by oncologists and staff, and not at hospitals, or other medical practitioners' offices; about half of all U.S. cancer patients are on Medicare—i.e., over 65 years old. Therefore, what happened as of April 1, is that, when the Obama CMS—Centers for Medicare & Medicaid Services—cut Medicare reimbursements for chemo drugs and overhead, under the excuse of sequestration, cancer clinics nationwide were faced with losing money to the degree they cannot remain in operation, if they continue with "too many" Medicare patients. This is especially true if the patients are on expensive drugs, for which the clinic will lose the most money.

Hundreds of clinic systems have sent out notices to select numbers of their Medicare patients, informing them that they can no longer get chemo at their customary clinic. These patients are told to try elsewhere. Thousands of sick people are scrambling about, not knowing what to do. Some are turning to hospitals for their infusions; but many community hospitals have no redundancy, to provide more care. Thousands of poor, elderly cancer patients have no recourse, and are going off chemo, to a sure, and possibly early, death.

The specifics of the Medicare reimbursement cuts are that, while sequestration is said to be an across-the-board reduction of "only" 2%, the way it actually affects chemotherapy treatments in community clinics amounts to a cut of 4.5% or more. This results from the fact that Medicare reimburses the clinics for the cost of the chemo-drugs, plus 6% to cover the expenses of storing and administering them. The market prices of the drugs are fixed; so, in effect, the 2% cut must come out of that 6% for overhead, which, according to some reports, such as that by MSNBC's Max Lockie on April 7, adds up to a double-digit pay cut for personnel.

"If you get cut on the service side, you can either absorb it or make do with fewer nurses," the director of the Community Oncology Alliance, Ted Okon, told the *Washingon Post*. Dozens of clinics say they cannot absorb this and stay in business.

The current sequestration blow to community clinics comes on top of the problem that, since 2008, over 1,200 such infusion operations have closed, or consolidated, or gone into financial arrears. In poor, rural areas, the shortage of clinics is severe. People face driving long distances, the need to stay overnight, etc. Many just give up.

On March 13, the associations representing cancer clinics, oncologists, and staff, issued an emergency appeal to Congress, warning of the dire impact if the sequestration was allowed to proceed (see *Documentation*). One of the 20 signator entities, Community Oncology Alliance, has posted a petition on the official White House website, to end the treatment cuts.

As of this week, Congress comes back into session, to hear their office phones jangling, from home district callers, furious over the cancer treatment debacle. The White House remains intransigent. On April 4, Brian Cook, the Media Relations person for CMS, said that the agency can do nothing. Referring to the costs of cancer drugs, he told the *Washington*

Post, "We are unaware of any authority that could exempt [Medicare] Part B drugs from the sequestration requirements."

Thousands Cut Off from Chemo

Examples of clinic notices and statements, cancelling treatment, were reviewed in the April 4 *Washington Post*, the April 3 heraldonline.com (South Carolina), and are now getting covered in the local media cross country:

New York: The North Shore Hematology Oncology Associates held an emergency meeting April 2, and decided to discontinue treatment for a third—over 5,000—of their 16,000 Medicare patients. CEO Jeff Vacirca said, "The drugs we're going to lose money on, we're not going to administer right now." He said, "A lot of us are in disbelief that this is happening. It's a choice between seeing these patients, and staying in business. . . ."

Connecticut: The Medical Oncology and Blood Disorders clinic stated in their March letter, "We will not be able to treat our Medicare patients effective April 2013."

South Carolina: The Charleston Cancer Center has given selected patients advance warning that their treatment may end soon. Dr. Charles Halladay said that, "We tell them that, if we don't go this course [cutting off the most expensive cases], it's just a matter of time before we go out of business."

This poster is part of a nationwide mobilization in opposition to Obama's Medicare cancer cuts.

Ohio: Zangmeister Center, Columbus. Dr. Mark Thompson, who is also president of the national Community Oncology Alliance, said, "Never before have I been forced to consider financial concerns when deciding which patients to treat. Oncologists should not be put in the untenable position of continuing to treat patients at a loss—which will result in clinic closings—or being unable to treat Medicare seniors fighting cancer, in order to keep the clinic doors open."

This assault on patients and treatment delivery, comes on top of ongoing undercutting of cancer screening, and shortages of cancer treatment drugs. For example, since the 2009 U.S. Preventive Services Task Force said that women in their 40s should forgo annual breast cancer screenings unless they knew of exceptional vulnerability—in the next year alone, there were 54,000 fewer screenings in this age bracket. Ten years ago, there were 13,400 mammography machines in the U.S.; today, there are fewer than 12,000. More than 870 counties (out of 3,141) have none at all.

Fight Cancer: Glass-Steagall

What is required, is to immediately cancel any cutting of government functions, and to initiate specific emergency measures to continue and expand medical treatments, diagnostics, and logistics of all kinds for health care. The lead of this effort, is for Congress to re-instate the 1933 Glass-Steagall law, to re-establish sound banking, in order to have the basis to rebuild the economy, and end the current killer-austerity policy being implemented in furtherance of the bail-out/bail-in support of the dead system of monetarism and speculation.

By contrast, look at the thinking associated with the build-up of the U.S. medical-treatment system, in particular, to fight cancer, during the post World War II de-

cades. It took place in the context of the pro-production outlook of that time, in which banking and credit were understood as the means to fund activity to create a more productive future, not financial gambling.

The principle was expressed most strongly in the 1946 "Hospital Survey and Construction Act," known as Hill-Burton, for its bipartisan Senate sponsors, Lister Hill (D-Ala.) and Harold Burton (R-Ohio). It mandated Federal/state/local collaboration for a nationwide hospital-building program, designed to provide the necessary number of staffed hospital beds per 1,000 people throughout the nation, ranging from 4.5 beds per thousand in urban areas to 6 in rural locations. By 1950, plans for new hospitals, or expansions of existing facilities, were underway across the nation. In the 1930s, out of 3,076 counties in the U.S., there were 1,282 with no hospitals at all, plus many in operation were substandard. This was all corrected by the 1970s.

In line with the Hill-Burton principle—that is, to provide desired ratios of treatment logistics per thousand people (hospitals, equipment, physicians, nurses, staff, public-health services, etc.)—a national plan was also initiated to fight cancer.

In October 1953, Congress convened a series of hearings on "The Causes, Control, and Remedies of the Principal Diseases of Mankind," held by the House Committee on Interstate and Foreign Commerce. Each session had a different focus, such as "Health Inquiry on Cancer" and "Health Inquiry on Poliomyelitis."

At the sessions on cancer, goals included reviewing the latest scientific understanding and questions about the disease, and to evaluate what could be done everywhere, to improve the *logistics of how to detect and treat cancer.* "National Inquiry" maps were presented, showing the location of current cancer detection centers and cancer clinics, in order to determine where more must be provided.

For example, in the 1950s, the cancer incidence rate was 34.3 per 1,000 persons over 60 years of age, in contrast to younger age brackets (e.g., it was 3.9/1,000 for ages 40 to 49), so more cancer diagnostic facilities needed to be located in areas with older citizens. This was undertaken.

However, since the 1970s, this build-up has all been drastically reduced. The takedown of the U.S. healthcare delivery system came in line with the 1970s national and worldwide shift to floating currencies and casino economics. In 1971, the Health Maintenance Organizations (HMOs) were sanctioned by Federal law for the first time. Hospital systems came to be deregulated, with fire-sale sell-off of non-profit community facilities, to privatized, for-profit syndicates.

Nationwide, the beds-per-thousand and all other critical ratios have declined below the danger point, to where the United States hospital system could barely manage to even cope with the annual 2012-13 influenza season.

Now, even this takedown is not enough for those demanding austerity to-the-death, in the name of deficit-reduction, budget cuts, fiscal responsibility, etc. Their deliberate action to cause cancellation of cancer therapy for the old and poor, and to endanger and shut down the U.S. community cancer clinics, is a call to action to change the system. Issue DNR for Wall Street—Do Not Resuscitate.

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Documentation

Tell Congress: Stop Cuts to Medicare Cancer Patients

The following is the full text of a letter sent March 13 to the leaders and full membership of Congress, by 20 entitites representing the core cancer treatment sector of the United States. Among them are the American Society of Clinical Oncology, the Colon Cancer Alliance, Lung Cancer Alliance, Leukemia and Lymphoma Society, Society of Gynecologic Oncologists, and many associations representing treatment centers, including the Association of Community Cancer Centers, and Community Oncology Alliance.

Dear Majority Leader Reid, Minority Leader McConnell, Speaker Boehner and Minority Leader Pelosi:

Community-based cancer care, where until recently four out of five Americans with cancer were treated, is in serious crisis. The April 1 payment cut to Medicare mandated by sequestration further threatens to destabilize our nation's precarious cancer care delivery system. Representing America's cancer care providers, cancer patients, and other organizations and companies affiliated with the cancer care community, we urge you to

reject Medicare cuts to life-sustaining anti-cancer drug and biologic therapies.

Over the past four and a half years, 241 community cancer clinic sites have closed and 442 practices (often with multiple clinic locations) are struggling financially. As community cancer clinics close their doors, access to cancer care is compromised for cancer patients, especially vulnerable seniors covered by Medicare. Additionally, 392 clinics have consolidated into the hospital, with consolidation driving up costs to cancer patients and payers.[1] According to recent studies by Milliman[2] and Avalere,[3] cancer patients, Medicare, and private insurers pay substantially less for cancer care when chemotherapy is administered in the physician community cancer clinic setting. Unfortunately, this cancer care crisis will seriously worsen with the sequestration-mandated cuts to Medicare effective April 1—access problems will multiply and costs will increase for both Medicare beneficiaries fighting cancer and taxpayers.

The Medicare Modernization Act of 2003 requires that all discounts and rebates be included in the calculation of Average Sales Price (ASP), the basis for Medicare drug reimbursement. The ASP formula mistakenly includes prompt pay discounts that pharmaceutical manufacturers extend to distributors for timely payment. This flaw artificially lowers Medicare payment for life-saving anti-cancer drugs, resulting in reimbursement below cost for many and eroding the viability of community cancer care. Even without the threat of sequestration payment cuts, 27 bipartisan members of Congress joined Representatives Whitfield, Green, Nunes, Kind, and DeGette as original cosponsors of a bill (H.R. 800) to remove manufacturer-to-distributor prompt pay discounts from the calculation of ASP and provide some additional stability to the nation's currently unstable community cancer care delivery system.

In stark contrast to this supportive legislation, imposing additional Medicare payment cuts to cancer drugs at this time would be devastating to both community cancer clinics and their vulnerable patients. Without a correction to the flawed Medicare payment formula, numerous additional cancer clinics will limit services or close altogether, restricting access to care or forcing cancer patients to more costly providers of care. When patients have to travel outside their communities for care, it can often result in duplicative and unnecessary services, additional co-pays, added transportation and lodging costs, and physical and emotional suffering, not to mention delays seeking treatment even as cancer progresses.

We implore you to help protect the cost-effective, high-quality cancer care delivery system for Medicare seniors fighting cancer. As Congress continues negotiations on the sequester and other federal budget matters, we ask that you keep in mind the millions of Americans who depend upon the life-sustaining drug and biologic therapies community cancer clinics provide, and the significant challenges those centers face in meeting in sustaining operations. At this time of both great promise and vulnerability in cancer care delivery, we need to strengthen, not undermine, patients' access to quality and cost-effective treatment in their communities.

1. *Community Oncology Practice Impact Report*, Community Oncology Alliance, March, 2012
2. *Site of Service Cost Differences for Medicare Patients Receiving Chemotherapy* Milliman, October, 2011
3. *Total Cost of Cancer Care by Site of Service: Physician Office vs. Outpatient Hospital* Avalere Health, March, 2012