

## » ONCOLOGY PATIENT CARE NOT AFFECTED BY CHANGES IN MMA

**On-Conversation with Kevin A. Schulman, Professor of Medicine and Business Administration, Director, Center for Clinical and Genetic Economics, Associate Director, Duke Clinical Research Institute Duke University Medical Center, Durham, NC**



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When President Bush signed the Medicare Modernization Act (MMA) into law on December 8, 2003, there were dire predictions of reductions in care for patients with cancer, and of widespread business failures among oncologists. A study recently published from Duke University's Clinical Research Institute argues that patient care has not suffered.

The study titled, "Association Between the Medicare Modernization Act of 2003 and Patient Wait Times and Travel Distance for Chemotherapy," appears in the July 9 issue of *JAMA*. The lead investigator, Kevin Schulman, MD,

agreed to an interview with OBR. Following is an excerpt of that interview, but first here's a review of the study's findings.

The study compared patient wait times and travel distances for chemo-

therapy before and after the enactment of the MMA, and used as a data set a nationally representative 5% sample of claims from the Centers for Medicare and Medicaid Services for the period 2003 through 2006. Patients were Medicare beneficiaries with incident breast cancer, colorectal cancer, leukemia, lung cancer, or lymphoma who received chemotherapy in inpatient hospital, institutional outpatient, or physician office settings. The main outcome measures were days from incident diagnosis to first chemotherapy visit, and distance traveled for treatment.

The study found a few small but significant changes. The proportion of patients receiving chemotherapy in inpatient settings decreased slightly, and the proportion in institutional outpatient settings increased slightly. The proportion in physician offices remained exactly the same. Average travel distances were slightly longer. The study concluded that there have not been major changes in travel distance and patient wait times for chemotherapy in the Medicare population since 2003—the year preceding the MMA's changes in reimbursement.

**OBR:** Your study concluded that MMA's changes in reimbursement for outpatient chemotherapy drugs and drug administration services did not negatively affect access to chemotherapy for Medicare beneficiaries. Is that correct?

**KS:** Yes, it measured in three different ways: by location of service, by the time of service or promptness of service, and the distance to the site of service.

**OBR:** For four straight years, between 2003 and 2006, the proportion of patients receiving chemotherapy in physician offices held steady at 68.7%, in spite of predictions to the opposite.

**KS:** That was the whole reason why we did the study. We also published a study last year in *Cancer* (Friedman JY et al. *Cancer*. 2007;110(10):2304-2312), which was a convenience sample of patients, done over the Internet, where we also found no patient-reported barriers in terms of distance, or decrease in satisfaction with services.

**OBR:** With the current study, did you expect to find more oncologists sending patients to hospitals?

**KS:** Yes. That was definitely the preponderance of comments in the lay press, so we looked to see if that was occurring.

**OBR:** If MMA didn't change patient flow, is it safe to assume that patient care didn't change, either?

**KS:** Again, in conjunction with this other convenience sample, we had patients' interpretations of whether or not their satisfaction with quality of care had changed. We didn't see a lot of evidence of that. Moreover, what we don't have, and which is almost impossible to find, is some measure of quality of care for oncology patients. So we can't say whether or not the quality of care this population received had changed.

**OBR:** Did the number of physician offices change in the period 2003-2006?

**KS:** We really can't answer that question with these data. But if the number of physician offices were substantially reduced, we would have expected to see an increase in distance, or at least some increase in the time to chemotherapy, which we didn't see.

**OBR:** Why did wait times in rural areas increase?

**KS:** Wait times are larger to begin with in rural areas. The wait time between diagnosis and chemotherapy for patients in rural areas increased from 26 days to 29 days, which was at a *P* value of .04, which is kind of marginal in a large data set like this. The travel distance for people in rural areas also increased from 22.7 miles to 23.9 miles, again a *P* of .04.

**OBR:** Which is also marginal.

**KS:** Yes, but we did say we were concerned about this. If we were to ask if is there anything that warrants further exploration, this is one area that might merit that.

**OBR:** Do you think that's due to office closures at all?

**KS:** We didn't measure that and couldn't. The data is from 5% of all patients in the Medicare Fee for Service Program. So at the individual physician level, we couldn't measure that because we're really only looking at about 5% of patients in the office practice setting. We'd be hard pressed to make strong

statements out of that. However, we are interested in looking at this measure and would love to do it if we could get a 100% sample—which would be all the Medicare beneficiaries who had a cancer diagnosis. We'd be happy to review that data if people were interested in it. In turn, that would give us a lot more information on rural patients who aren't that large of a segment of the population. It would also give us more information on minority patients. We could then begin to look at things at the provider level, at least for a practice's Medicare patients.

**OBR:** Does the demonstration project have the potential to be a variable in your study?

**KS:** Well, we account for it each year, and as that program has changed, that would get accounted for in the year affected.

**OBR:** In general, MMA changes seem like such a drastic cut in revenue and income. How have oncologists coped with this?

**KS:** The issue from the beginning was whether or not Medicare was paying appropriately for chemotherapy services. To some extent the test of that was whether or not changes in reimbursement resulted in changes in access to patient care. In other words, were physicians dropping out of the Medicare program? We didn't see any proof of that. Obviously, their business has been impacted, but it seems not to the point where they've closed shop to new Medicare beneficiaries.

**OBR:** Is there anything you'd like to add?

**KS:** There were huge concerns about these changes from a variety of different perspectives. The good news is that we haven't seen changes in patient access. But I think we still need to continue to evaluate these policy changes as they continue to move forward. **OBR**



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