Community oncologists endangered

When it comes to cancer treatment reimbursements, community oncologists just cannot compete with large hospital networks that have both the funds and the congressional protection to continue treating patients. As patients transition to high deductible health plans, out-of-pocket costs per patient go up considerably, which makes cancer care increasingly difficult for patients to afford.

Oncologists have fought for and support payment parity in cancer care, regardless of where the service is provided — clinic or hospital. Our pleas continue to fall upon deaf ears.

My three colleagues and I are the only independent community oncology group practice in Baton Rouge. We send 20 to 30 percent of our chemotherapy patients to the hospital because — due to the current Medicare reimbursement policy favoring hospitals over private practices — we often are not reimbursed for our costs to administer chemotherapy, let alone being able to generate enough revenue to sustain our practice.

It is easy to put the blame on the rising cost of cancer care, but the culprit is actually a one-two punch: across-the-board budget cuts, known as sequestration, and hospitals swooping in and absorbing private practices, often because of the 340B program. The 340B drug discount program provides a very valuable safety net for helping to ensure that patients in need — both uninsured and underinsured — receive medical treatment. However, with relatively little oversight, the 340B program is being used by hospitals to acquire physician-owned community cancer clinics. These acquisitions add to hospitals' operating profits by creating incentives that can be detrimental to patient care and that can lead to increased costs for patients, Medicare, and insurers. The 340B program has allowed qualifying hospitals to realize increased revenue by accessing 30 to 50 percent discounts on outpatient drugs.

In less than a decade, 544 community cancer practices have been acquired by or affiliated with hospitals and 313 cancer treatment facilities have been forced into closing their doors, according to the Community Oncology Alliance's 2014 Community Oncology Practice Impact Report. Every study has shown that care in a hospital outpatient setting costs patients and the healthcare system more than the same care when provided in a physician office-based setting. This trend of closures and absorptions increases the cost of cancer care, complicates treatments, and hurts oncologists who want to win the fight against cancer but face unsustainably low reimbursement.

Community cancer care providers are often faced with a very real choice: close their offices or sell out to a hospital. When I have to send my patients to the hospital, treatment takes longer and the cost is higher. It not only inconveniences the patient, but I lose their trust. And that means more to me than anything. With site parity and a level playing field, we can deliver quality care and support the community oncologists who remain dedicated to providing access to local care.

Therefore, I ask, "Why is Congress allowing the cost of cancer care to rise by pushing care into the hospitals?" Personally, I think they would like us all employed by the hospitals so they could make one large devastating cut.

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