Commentary

Grassroots outreach making headway

By Ted Okon

The cancer community is finally realizing that it can shape legislative policy. Over the past 2 years, community oncology practices across the country have reached out to their representatives on Capitol Hill to educate them about the realities of delivering modern-day cancer care. Oncologists, nurses, practice administrators, and staff have been engaged with their patients, caregivers, and survivors in establishing an ongoing dialogue with their elected representatives to Congress.

The results speak for themselves

At the end of the previous (107th) session of Congress, there was a draft of a bill that would have changed the Medicare reimbursement system to a formula for drug payments to be equal to average selling price (ASP) plus 0%, with no increase in reimbursement for medical services. That bill never surfaced. In the current (108th) session of Congress, there was an attempt to insert language in the tax bill that would have decreased drug reimbursement to 85% of average wholesale price (AWP), with no increase in services reimbursement. That provision was removed from the tax bill, which was ultimately passed by the Congress and signed into law. Early attempts with the Medicare Modernization Act (MMA) to significantly reduce cancer care reimbursement starting in 2004 were overcome.

The cancer community has come together at the grassroots to engage their members of Congress in steering cancer care legislation in a more constructive direction. More members of Congress now understand the complexity, and cost, of delivering quality cancer care. Representatives and senators alike realize that under the old AWP-based reimbursement system established by Congress, the overpayment for cancer drugs subsidized the significant under-payment for essential medical services.

Now, the cancer community faces a challenge for 2005 as attempts to

better balance Medicare reimbursement for drugs and services will result in significant payment cuts. Drug reimbursement will decrease sharply as the new ASP-based system is implemented. Payment for services is also scheduled to decrease by 22%, as a transitional reimbursement increase of 32% in 2004 will drop to 3% in 2005.

Responding to the grassroots lobbying efforts of the cancer community, and requests from members of Congress, the Centers for Medicare & Medicaid Services (CMS) recently announced payment increases for certain cancer care services. Basically, these changes fall into three categories:

- creation of new codes for drug administration;
- creation of new codes for multiple drug administrations; and
- practice expense inputs for costs incurred in drug preparation and physician supervision.

These changes will go into effect on January 1, 2005. Additionally, CMS will publish information on the immediate use of existing codes to bill for complications and adverse events arising from chemotherapy administration. These changes were outlined in letters sent by Dr. Mark McClellan, CMS Administrator, to members of Congress involved with the issue of Medicare reimbursement for cancer care. Those members include Congresswoman Nancy Johnson (R-Conn), chair of the House Ways and Means Health Subcommittee, and Congressman Max Burns (R-Ga), both of whom authored a letter to Dr. McClellan, which was co-signed by 20 representatives, expressing concern about cancer care payments.

At the time of this article, the Community Oncology Alliance (COA) is in the process of evaluating the real impact in dollar terms of these announced changes.

Reimbursement issues

Regarding drug reimbursement and the ASP system, this still remains a disconcerting open issue. CMS has released preliminary drug reimbursement rates—based only on first-quarter 2004 ASP data—for certain cancer drugs, excluding most generic drugs. CMS has not released any data on second-quarter 2004 ASP information provided by pharmaceutical manufacturers and has changed the ASP calculation methodology for the third quarter 2004. The new ASP calculation methodology for the third quarter will produce unknown results—meaning, there will be no basis for comparison. Since the third-quarter ASP data will form the basis for the drug reimbursement rates that go into effect January 1, 2005, there will be enormous uncertainty about the accuracy of these rates and their stability.

The rush to implement new Medicare changes without sufficient data and analyses is the reason why the cancer community has called on the Congress and CMS to create a transition year during 2005. This would involve running the current and new reimbursement systems in parallel, with a safety net and allowing for refinements to the new system backed by data and analyses.

The changes recently announced by CMS are certainly a step in the right direction. However, there is a rush to implement new systems that are simply not ready and that do not adequately reflect the total cost of delivering modern-day cancer care.

There is a credo that medical professionals follow about "doing no harm to the patient." The cancer community has been actively seeking for reform of a broken, unbalanced Medicare reimbursement system for cancer care. However, that reform needs to protect cancer care delivery in this country without putting any additional burden on those Americans battling this terrible disease.

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