Commentary

Medicare changes must be made now

Ted Okon | Community Oncology Alliance, Memphis, TN

There is no doubt that the changes to reimbursement for cancer care brought about by the Medicare Modernization Act of 2003 are a step in the right direction toward balanced payment reform. Unfortunately, they fall short of realistic payment for cancer drugs and services. Undoing the previous system—in which paying for drugs subsidized paying for services such as treatment planning and management, pharmacy functions, and chemotherapy administration—has left payment voids for these essential medical services. Ironically, the unintended consequence of these changes is the potential to actually increase the cost of cancer care to Medicare and make it more difficult for patients to gain access to care.

Late last year, the Government Accountability Office (GAO) issued a report that justified the new Medicare drug payment system based on average selling price (ASP). However, the GAO report was flawed in that it used preliminary ASP data, not actual Medicare reimbursement rates. Based on real first-quarter 2005 drug payments, Medicare reimbursement rates for first quarter 2005 *are less than cost* for 6 of the top 16 cancer drugs analyzed by the GAO. These 16 drugs comprise three quarters of Medicare spending. As an example, generic Taxol (paclitaxel) is reimbursed by Medicare at a rate 14% below cost, as reported by the GAO report. If you factor in bad debt—resulting from patients unable to pay their Medicare co-insurance—13 of the top 16 cancer drugs are reimbursed at a rate lower than cost.

The old Medicare system based on average wholesale price was intentionally set up so that drug payments would cover certain aspects of cancer care not reimbursed directly—including all of the pharmacy functions directly related to cancer drugs, such as storage, inventory, and waste disposal. These functions have increased in cost as the complexity associated with handling cancer drugs has increased. Unfortunately, the new Medicare drug reimbursement of ASP plus 6% does not adequately cover these essential pharmacy functions and the onerous regulatory requirements.

Although Medicare did increase payment for the administration of chemotherapy, reimbursement does not cover all of the extensive planning required of oncologists in treating cancer patients. As any oncologist knows, providing medical care to a person with cancer requires an individualized treatment plan tailored to the patient's diagnosis, overall medical condition and history, age, and disease prognosis. It is ironic that the Centers for Medicare & Medicaid Services (CMS) already reimburses radiation oncologists for treatment planning but, for some reason, overlooks medical oncologists, especially since the treatment plans developed by medical oncologists most often include radiotherapy as a component.

CMS needs to take immediate action to protect access to high quality, affordable cancer care by taking the following steps:

■ *1. Increase Medicare reimbursement for all cancer drugs and cancer-related drugs (supportive care drugs, IV antibiotics, etc) where the reimbursement rate is artificially lower than costs.* The definition of ASP needs to be modified such that discounts for prompt payment—which constitute financing decisions and have nothing to do with actual drug price—are eliminated from the calculation of ASP.

■ *2. Create a treatment planning code for medical oncology, as currently exists for radiation oncology.* This code—or several codes to account for the level of planning required—should be based on the complexity of the treatment planning required and tied directly to the intricacies of the treatment protocol prescribed. Underpinning the code (or codes) should be parameters that enhance the quality and safety of the treatment plan. This essential component of cancer care is not covered in the evaluation and management (E&M) codes now in use. It is also not covered in the chemotherapy administration codes. Under the old Medicare reimbursement system, it had been adequately covered (ie, subsidized) by the drug reimbursement.

■ *3. Create a pharmacy facilities fee, with quality parameters, to cover increasing drug storage, inventory, and waste-disposal requirements.* This direct drug cost is not adequately reimbursed as it was in the past, when it was subsidized by drug payments.

■ *4. Factor in bad debt as a reality of cancer care.* Bad debt is primarily attributable to Medicare beneficiaries with no secondary insurance (and in some cases with Medicaid as their secondary insurer). There will be higher costs to Medicare if patients who cannot pay their 20% co-insurance fee are treated in the hospital.

■ *5. Extend the demonstration project into an ongoing quality initiative for the assessment and management of*

© 2005 Elsevier Inc. All rights reserved.

important cancer- and chemotherapy-related symptoms. This project is set to expire at the end of 2005. Documented as under-assessed symptoms related to cancer and chemotherapy, fatigue, pain, and nausea and vomiting often result in costly medical intervention, if left unmanaged. This demonstration project is the first major pay-for-performance program implemented by CMS for cancer care; it should be turned into an ongoing initiative. Eliminating this funding will decrease Medicare reimbursement for cancer care by an additional $300 million, thus substantially increasing the cancer care cuts and far exceeding Congressional intent.

Thirty years ago the government declared war on cancer; since then, we have made great inroads against the disease. However, each day, 1,500 Americans still die of cancer. We need to work with policymakers to strengthen the community cancer-care delivery system and develop viable, realistic payment systems.

Ted Okon is Co-Executive Director of the Community Oncology Alliance, based in Memphis, TN. He can be reached at taokon@sosacorn.com.