Commentary

Medicare reimbursement ratcheting down

Ted Okon and Steve Coplon | Community Oncology Alliance, Memphis, TN

With the release of Medicare drug reimbursement rates for second quarter 2005, it is now apparent that community cancer clinics are experiencing a severe ratcheting down of payment for cancer care—despite a rosy scenario painted by the Government Accountability Office (GAO). (See box on page 280.) Unfortunately, the GAO analysis has proved to be seriously flawed. The reason: it used estimated drug reimbursement rates based on average selling price (ASP), not actual rates.

The Community Oncology Alliance (COA) updated this analysis by plugging in actual Medicare payments for 16 of the cancer drugs examined by the GAO. The total average cost of these drugs exceeds Medicare reimbursement by more than $80 million annually. Extrapolating out to the universe of cancer drugs, the total cost incurred by community cancer clinics exceeds Medicare reimbursement by an average of more than $110 million.

The inherent problems with the ASP-based system are exacerbated by recent price increases for cancer drugs. For example, the price of Herceptin (trastuzumab) was increased by 4.4% at the end of February. Because there is a 6-month lag between the reporting of drug ASP data by pharmaceutical manufacturers to the Centers for Medicare and Medicaid Services (CMS) and the publishing of drug reimbursement rates based on those data, community cancer clinics will be subsidizing Medicare for the Herceptin price increase. It will take 7 months before the 4.4% increase is reflected in Medicare drug payments.

Piling on

The reimbursement landscape for community cancer care is not looking any brighter, as private insurers are now announcing that they intend to adopt the Medicare ASP-based drug payment system as early as third quarter 2005. Some insurers have announced that they will not increase payments for services, such as chemotherapy administration, as Medicare has. These private payers don't intend to adopt the Medicare demonstration project that compensates community cancer clinics for the assessment of fatigue, nausea, and pain.

Because the demonstration project will expire at the end of 2005, community cancer care will experience an approximately $400 million decrease in Medicare payment for medical services next year. The transition fee increase for chemotherapy administration will be eliminated, and the physician fee schedule is set to decline by more than 4%. Based on the pattern in 2005, community cancer clinics can expect drug reimbursement rates to continue falling.

Tipping the CAP

CMS has touted the competitive acquisition program (CAP), scheduled for implementation in 2006, as the salvation for decreasing drug reimbursement. However, CAP—also referred to as mandatory vendor imposition (MVI)—is a concept, not an actual program. No payer has ever implemented CAP as a viable, alternative cancer drug delivery system. Developed without input from community oncologists, the CAP concept is intended to extract community cancer clinics from the drug procurement business with the goal of saving Medicare money. However, it will actually cost Medicare more money than the current clinic drug procurement system. Here's why:

- Vendors taking part in CAP will be paid for shipping, administration, and a management fee. Factored into this will be any bad debt they incur. These

GAO's crystal ball

In its December 1, 2004, report to House Energy and Commerce chairman Joe Barton (R-Tex.) the Government Accountability Office concluded:

"In summary, we estimate that Medicare payments for drugs billed by oncologists in 2004 and 2005 will decline relative to 2003, while still exceeding physicians' costs for acquiring these drugs, and payments for chemotherapy administration services will increase substantially. Medicare payment rates for the 16 drugs we studied will exceed oncologists' estimated costs for acquiring these drugs by 22% in 2004 and 6% in 2005."

are all additional costs to Medicare.

- Most cancer drugs used today—which comprise the major part of Medicare spending—are only available from a single source. Pharmaceutical manufacturers have no reason to competitively bid these drugs to CAP delivery vendors. In fact, best prices will always be obtained by community cancer clinics that control the end use of cancer drugs.

Move on

So why fix a cancer drug delivery system that isn't broken? A system that has proved to be safe and efficient? Using CAP—a concept that will not be tested under tightly controlled conditions similar to those used for new drug safety testing—is very dangerous. It will likely result in multiple drug inventories, new administrative burdens for cancer clinics, and even more medical liability for clinics dealing with a new type of drug delivery middleman.

COA has been providing to the United States Congress data and analysis in support of its solution to fix ASP, pay for treatment planning and pharmacy facilities, and extend the demonstration project. We are encouraging community cancer clinics across the country to reach out to their representatives in the Senate and the House of Representatives. Many clinics have gone so far as to bring members of Congress into their chemotherapy chairs so policymakers can get a feel for cancer care firsthand.

The time is now to fix the reimbursement problems before this situation escalates into a major crisis, barring patients from access to care. We urge you to reach out and educate your elected officials. We need creative solutions to avert a mounting crisis and to strengthen the cancer care delivery system for years to come.

Ted Okon and Steve Coplon are Co-Executive Directors of the Community Oncology Alliance, based in Memphis, TN. Mr. Okon can be reached at taokon@sosacorn.com, and Mr. Coplon can be reached at scoplon@westclinic.com.