

From the 10th Annual National Comprehensive Cancer Network Conference

Grappling with the consequences of the Medicare Modernization Act

It thrums along for 1,000 pages, only 10 of which pertain to cancer. But those 10 pages, embedded deep in the Medicare Modernization Act (MMA), have set the oncology community—from patient advocates, to clinicians, to pharmaceutical companies—on its collective ear. Each constituency has its own worries: lost income, reduced access to care, and lowered quality of care. They vented those concerns recently in a roundtable discussion marked by uncertainty and apprehension at a meeting of the National Comprehensive Cancer Network (NCCN) in Hollywood, Florida.

Medicare's new formula of average selling price plus 6% (ASP + 6) "is a tectonic shift that upends the apple cart of cancer payment," said Clifford Goodman, PhD, who moderated a roundtable discussion at the meeting. Dr. Goodman is a consultant with the Lewin Group, a health care policy research and management consulting firm based in Falls Church, Virginia. When he asked patient advocate Ellen Stovall of The National Coalition for Cancer Survivorship whether she believed there would be a tradeoff between cost and the quality of care, she said yes, adding that "oncologists are tormented by this. They are having an ethical dilemma in terms of their decision making. I think that most doctors will do the right thing, but there will be a cost to the practice, which is a cost to the patient."

Co-pays: a delicate issue

The effect of the MMA on collecting co-insurance payments may be one of the biggest unintended consequences of the Act, said Dr.

Goodman. "Theoretically, patients were always supposed to pay about 20% in co-insurance," he said. Traditionally, it's been difficult to collect, and, frankly, Medicare's overpayment for chemotherapy in the past was enough so that there was less of an incentive for doctors to pursue it. Now, with finances tighter, there is more of a need to recoup those co-insurance payments."

At the Redwood Regional Oncology Center in northern California, Kristine J. Hartigan, RN, OCN, said, "The family issues have been so sensitive, we've written off a great amount when patients die. Now we're trying to help patients find additional resources. And we have to educate our staff to collect the money."

Will this emphasis on collecting co-insurance change patients' care-seeking behavior and thus health care outcomes? Ms. Stovall, for one, believes it will. "Before, patients never fully realized the cost of their care," she said. "Now they are going to find that some of the novel therapies for nausea, pain, fatigue, and vomiting that allow them to continue their lives uninterrupted are very expensive."

Keeping the practice in business

The survival of smaller oncology practices struck several participants as highly uncertain, with market forces bringing more pressure to bear on them compared to larger cancer care centers. For one thing, they have to compete with larger groups for fair prices when buying drugs.

Pricing is somewhat different depending on the size of the group a manufacturer is selling to. The groups

range from large purchasing organizations to small practices of two or three doctors. The smaller groups don't fare as well. And when drug choices are limited, they pay top dollar. Dr. Goodman gave an example of the dilemma oncologists now face: "In metastatic breast cancer, you have several drug choices. But with pancreatic cancer, you have just one drug. ASP paying less can't move you off that drug." Redwood Oncology has already felt the squeeze. "We were surprised by our first-quarter data," said Ms. Hartigan. "We didn't expect to buy so many drugs at a loss."

Health care safety net

The Centers for Medicare & Medicaid Services (CMS) is the largest health insurance organization in the world. It covers 41 million people in this country—that's one in seven Americans. CMS calls the Medicare Modernization Act of 2003 "the most dramatic and innovative change to the Medicare program since the program began in 1965." Individuals older than 65, non-elderly disabled persons, and people of any age with end-stage renal disease qualify for Medicare.

Considering the changing payment environment, "there may be a redistribution of delivery of care," Dr. Goodman said. "There are some questions about whether there will be reductions in patients' access to community cancer centers, which can then have a domino effect on hospital outpatient and inpatient departments. There may be consolidation in the market, reducing the total number of centers, seriously affecting cancer patients' access to care."

Patients living in rural areas could be hit the hardest. "Many of our patients can't easily get to academic cancer centers," said Ms. Hartigan of her far-flung northern California constituency.