

## Commentary

# New CMS demonstration project and significant payment cuts ring in 2006

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**T**his year, the Centers for Medicare and Medicaid Services (CMS) will be launching a new demonstration project for care of 13 types of cancer. At each office visit (corresponding to a level 2 through 5 Evaluation & Management code), oncologists will be required to submit data on the following three items:

- the primary focus of the evaluation and management service;
- the current disease state; and
- whether current management adheres to clinical guidelines.

The Community Oncology Alliance (COA) has major concerns about this new demonstration project:

**First, and foremost, Medicare has grossly underestimated the time needed to document, bill, and administer this data collection effort.** The per incident payment totals only \$23. Of that, Medicare will pay \$18.40; the patient is responsible for the co-insurance payment of \$4.60. Because Medicare has not kept pace with the increasing complexity of delivering cancer care, it lacks an understanding of what is involved.

**Second, the new demonstration project limits oncologists' guideline choices and unnecessarily complicates the collection of staging data.** COA has provided CMS with a list of these operational issues.

In part, the 2005 CMS demonstration project was implemented as a stop-gap funding source for community oncology. The Medicare Modernization

Act (MMA) mandated a 32% transition increase in 2004 so that CMS would add major and minor codes to ensure proper payment for essential medical services provided by community oncology clinics. In addition, CMS was to revise relative value units-based coding for chemotherapy administration. But this didn't happen during 2004 to the extent the MMA mandate intended. CMS deferred to a decision made by a panel of the American Medical Association not to add any new major codes to oncology, even though persuasive arguments were presented to the contrary. However, CMS did make several minor code changes. When Medicare realized that the 32% transitional increase was set to drop to 3% in 2005, CMS implemented the 2005 \$300 million demonstration project as a stopgap solution.

During 2005, CMS has not added any major or minor codes. Facing the expiration of the 2005 demonstration project, CMS has announced the new project for 2006, which will provide \$150 million in funding. On average, community practices from around the country report that this year they expect to be paid 35% of the demonstration project funding they realized last year.

The intent of the MMA was to reform the Medicare payment for cancer care so that the overpayment for drugs no longer subsidized the underpayment for medical services. Unfortunately, as is often the case with public policy, the pendulum has swung too far in the opposite direction. Community oncology clinics report that the reimbursement for

many cancer drugs has fallen below cost. Administering drug regimens, especially when factoring in administrative costs, overhead, and bad debt, to Medicare patients has become a financial drain. As a result, many practices say that they plan to send an increasing number of patients to the hospital rather than providing in-office treatment at a financial loss.

### Crying wolf

Since 2003, community oncology has been accused of "crying wolf" about patient access and clinic closings. A crisis was averted for 2004 because in late December 2003 CMS added an estimated \$530 million in services reimbursement for the following year. Again, a crisis was averted in 2005 because in late 2004 CMS added an estimated \$400 million in the form of the 2005 demonstration project and coding changes. However, the continued ratcheting down of average sales price-based drug reimbursement did result in more patients being sent to the hospital this past year. Now, community oncology clinics are facing an estimated \$300-\$400 million cut in Medicare services reimbursement.

According to the 2006 Medicare Physician Fee Schedule, reimbursement to community oncology will be cut by 10% in 2006. But that is an inaccurate accounting of an illogical act: the cut affects only medical services, and not drugs, which will increase in cost, due to inflation, by up to 5% from last year. That adds up to a Medicare payment cut closer to 15%.