

MMA and the law of unintended consequences

Community oncologists are being underpaid for drugs and services. That's according to a number of speakers at the Community Oncology Conference.

When Congress passed the Medicare Modernization (MMA) Act in 2003, lawmakers were looking to address an issue that had recently drawn much attention: the seeming irrationality for how the program paid for chemotherapy and other physician-administered drugs. Although the intention of that legislation was to pull \$4.2 billion out of cancer care by 2013, a recent PricewaterhouseCoopers analysis suggests it could be much closer to three times that, at an estimated \$15.7 billion loss to reimbursement, said Ted Okon, Co-Executive Director of the Community Oncology Alliance, Washington, DC. With the MMA, oncology practices are now subsidizing Medicare for every increase in drug prices, he said.

As a result of the law, reimbursement for in-office oncology drugs has been readjusted to a formula that was supposed to better reflect prices generally available in the market. However, that has not been the case in practice, as the so-called average sales price, or ASP, has often lagged market prices by months, he said.

Higher drug costs

Citing a specific example, Mr. Okon pointed to last year's 4.4% jump in the price of Herceptin (trastuzumab). It took Medicare

more than 6 months to adjust to the change, leaving practices to cover the difference. "This is not the fault of Medicare, and it's not the fault of the Centers for Medicare & Medicaid Services [CMS]. It's the fault of the legislation," he said, encouraging the community to lobby Congress for changes.

However, there have also been problems with implementation, said Mr. Okon. The change to drug reimbursement was designed to be accompanied by the addition of new codes that better reflect the cost that practices incur in providing in-house treatment to their patients. However, CMS has been slow to add major codes to the system. Additionally, ancillary costs, such as storage, inventory, pharmacy, and waste disposal—which were subsidized through drug reimbursement under the old system—are no longer paid for at all, said Mr. Okon.

The new system also has resulted in more uncompensated care for patients who cannot afford co-payments or other cost sharing. To drive this point home, he asked audience members to raise their hands if they had no bad debt. There was an uneasy laugh but no hands.

"Bad debt is the ultimate denial of reimbursement," he said.

Trickle down

The impact of these problems is already trickling down to patient care. Already this year, practices have reported sending more patients to the

hospital for physician-administered treatments, refusing new Medicare patients, closing satellite offices, and requiring patients to travel farther for treatment. "Reform is the right thing to do," said Mr. Okon. "But we have to work together to make sure it's fair."

CMS is working diligently to implement reform in a way that makes sense, including a demonstration project that is capturing more detailed information about treatment, said Peter Bach, MD, a clinical researcher at Memorial Sloan-Kettering Cancer Center in New York City, who is currently serving as a senior advisor to the agency's office of the administrator.

Physicians at the meeting voiced complaints about that demonstration project, details of which have been slow to reach the community.

"It was an extremely late announcement, as you all know, in '04, causing huge problems with implementation," said Dr. Bach. "We have repeated that delay this year, which we're well aware of."

"We are going to try to fix that as we move forward," he added.

Several members of both the panel and the audience expressed some consternation with those assurances, given the fact they are facing significant cuts to their reimbursement right now. The old system was flawed and encouraged some questionable billing practices, said Mr. Okon, "but now the pendulum has swung too far the other way."