

Commentary

Facing reality: cancer clinics and the full impact of MMA

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Community cancer clinics across the nation recently closed their books for the first quarter of 2006. The news is very sobering. Many practices are experiencing double-digit downturns in revenues. In terms of contribution to working capital, this reduction is even larger.

This is not surprising given the PriceWaterhouseCoopers report last year on the reimbursement for cancer care under the Medicare Modernization Act (MMA). The accounting firm projected that, over 10 years, savings are projected to be \$15.7 billion. This far exceeds the intent of Congress, which was to save \$4.2 billion. Practices were somewhat shielded in 2005, primarily by the \$300 million chemotherapy demonstration project, the remaining 3% of the chemotherapy administration transitional increase, and some transitional drug reimbursement issues. But in 2006, these shields are gone.

The situation will be exacerbated as 23 drug price increases now go into effect, even though clinics will not see increases in Medicare reimbursement for two quarters. That lag time means that cancer care for Medicare patients is now being significantly subsidized by the practices.

ASP + 6: a flawed system

Given the realities of the prompt pay discount inclusion in average selling price (ASP), the non-payment for pharmacy facilities costs, the distrib-

utor markup on drugs, bad debt, and other billing and administrative costs on drugs that are not covered, the current ASP system is substantially flawed and needs legislative and administrative corrections. When applying these realities, the typical practice is netting 7.8% below ASP. Given the drug price increases for 2006, this net drops to an average of 10.3% below ASP for at least two quarters. This system cannot sustain itself much longer without significant correction.

Between 2005 and 2006, reimbursement for most cancer care regimens has dropped dramatically (see below).

The solutions

The Community Oncology Alliance (COA) has championed a number of initiatives on various fronts:

Legislation

The Community Cancer Care Preservation Act, HR 4098 and S 2340 introduced in the House by Congressman Jim Ramstad (R-Minnesota) and in the Senate by Senator Arlen Specter (R-Pennsyl-

vania), makes positive corrections to MMA by:

- Removing Prompt Pay Discounts from the ASP formula;
- Providing a pharmacy facilities payment equal to 2% of ASP on the drug;
- Resolving the two quarter time lag associated with manufacturers' price increases by creating a "true up" mechanism;
- Continuing the 2005 chemotherapy demonstration project until the Centers for Medicare and Medicaid (CMS) makes permanent solutions on codes for essential services.

COA is also working with members of the House and Senate on initiatives dealing with bad debt caused by the inability for practices to collect all the 20% co-pay on the drugs.

Administration

COA is working with CMS on:

- Correcting the underpayment for the first hour of chemotherapy services. The rate established in 2004 was more closely in line with the real costs and value associated with the clinical

Examples of reduced Medicare reimbursements for cancer treatment regimens

Regimen	Indication	2005 to 2006 reduction
FOLFOLX + bevacizumab (Avastin)	Colorectal cancer	-32.90%
Paraplatin (Carboplatin) + paclitaxel (Taxol) every 3 weeks	Lung cancer	-33.65%
Low-dose paraplatin + paclitaxel weekly	Breast cancer	-38.68%
Paclitaxel + trastuzumab (Herceptin)	Breast cancer	-31.70%
Gemcitabine (Gemzar) + paclitaxel	Breast cancer	-33.65%
Docetaxel (Taxotere) + doxorubicin (Adriamycin) + cyclophosphamide (TAC)	Breast cancer	-32.74%

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team, especially the oncology nurses.

■ Correcting the severe underpayment for the second and subsequent hours of chemotherapy. This amount should be restored to its historic value of 70% of the first hour of treatment.

■ Valuing and paying for supportive care services. Typically, quality oriented clinics are assessing 35–40 symptoms and a whole array of other issues associated with quality of life that are currently not reimbursed.

Treatment planning

Medical oncologists and their clinics are the coordinators of cancer care treatment planning, yet they are not paid for the complex decision making needed for cancer patients. Years ago, codes were appropriately added for radiation oncology treatment planning. A similar model should be developed for medical oncologists.

Radiology reductions

Last year, COA recommended excluding cancer and related diagnoses from reductions in radiology. We continue to advocate for appropriate payment for these essential services, many of which save the system significant dollars.

Paying for quality

Community oncologists have embraced the concept of quality care, bearing in mind these principles:

1. **While elevating quality in the lowest-cost setting, practitioners have broadened access and protected the essential nature of the physician-patient relationship without any outside force providing a master blueprint to achieve these goals.**

2. **The evidence of quality improvement related to shifting care to the community setting can and has been measured by the Centers for Disease Control and Prevention and the National Cancer Institute.¹ The results are improved survival rates, a downturn in the death rates, im-**

proved quality of life, and more.

3. **To adhere to guidelines, we must agree on which guidelines are acceptable.** But cancer care is far more than a treatment guideline. To achieve quality care and minimize variation, we need to rely on comprehensive evidence-based treatment protocols.

4. **Because community oncologists provide care for 84% of the nation's cancer patients, they are the primary managers of interdisciplinary care and treatment planning.** These practitioners will transform the landscape and steer toward quality incentives.

5. **Electronic medical records are essential to taking quality care to the next level.** These costly technologies are less likely to be implemented when reimbursement for cancer care is below cost. Community oncology clinics have already taken a leadership role down this path and are now being hampered by reimbursement reductions and a "top-down" quality approach.

6. **Community oncology has saved Medicare and commercial payers billions of dollars by preventing more adverse events and by serving as disease managers for oncology.** The number of ER visits and admissions for anemia, neutropenia, esophagitis, and many more events is enormous. One leading practice in a mid-sized city calculated the savings resulting from effective adverse event management to exceed \$15 million annually (unpublished report issued to The Greater Memphis Area Quality Initiative, The Memphis Business Group on Health, and Lipscomb & Pitts Insurance Brokers, August 2005). As reimbursement is reduced, clinics will no longer be able to afford to staff sufficiently and proactively address these issues.

A word about CAP

CAP—the competitive acquisition program—is bad medicine, bad economics, and bad patient service

for oncology. Making clinical decisions is far too complex to be confined to an inflexible CAP model. There are enormous costs associated with implementing CAP. A national COA survey of more than 50 cancer clinics showed that as much as 35% of chemotherapy regimens change on the day of treatment. Several dozen practices across the nation were surveyed by The Connecticut Oncology Association and Cancer Clinics of Excellence. The preliminary data on the costs of potential drug wastage associated with chemotherapy changes on the day of treatment under a CAP or specialty pharmacy system are averaging \$1 million per year for a five-physician practice. And the program is also a major inconvenience to patients, whose treatment may change on the day they come to the office.

Conclusion

Massive revenue reductions to cancer clinics are real: Some clinics are no longer seeing Medicare patients, and others are talking about closing. The typical clinic has indicated to COA that it is shifting patients from the clinic to the hospital at a rate four times that in 2005. In one New York hospital, the total reimbursement of cancer care provided by a hospital was four times the reimbursement of that same care in the office. Is this what was intended when MMA sought to fix the cross-subsidy system?

While there is still time, Congress and CMS must make the corrections needed to undo this crisis. Everyone reading this article should consider his or her role as an advocate for the clinics and the patients they serve.

Reference

1. Annual report to the nation finds cancer incidence and death rates on the decline: survival rates show significant improvement. National Cancer Institute Web site. Available at: <http://www.cancer.gov/newscenter/press-releases/ReportNation2004release>. Accessed April 25, 2006.