

Commentary

Congress hears testimony on Medicare concerns

By Steven M. Coplon

The Health Subcommittee of the House Ways & Means Committee held hearings in July addressing many of the fundamental concerns expressed by cancer clinics across the country. Among the witnesses were representatives of the Centers for Medicare and Medicaid Services, Office of the Inspector General, Government Accountability Office, Medicare Payment Advisory Commission, as well as cancer groups and organizations affected by access issues for intravenous immunoglobulin (IVIG).

Several members, including Congressman Jim Ramstad (R-MN), asked Medicare why codes had not been created to cover oncology treatment planning and pharmacy facilities. Mr. Ramstad cited the greater than 30% reduction in drug reimbursement and greater than 20% reduction in essential services reimbursement. "Why in the world have there been no permanent solutions to maintain critical Medicare funding for cancer care?" Mr. Ramstad asked. "Why not, for example, add payment codes for treatment planning, as has been suggested earlier?" Rep. Ramstad introduced HR4098, The Community Cancer Preservation Act, a bill that currently has 75 co-sponsors. Senator Arlen Specter submitted a companion bill in the Senate, S2340.

In the red

During the hearings, several members of Congress highlighted the financial struggles that many clinics are facing. Congressman Kenny Hulshof (R-MO) recounted his visit to a cancer clinic in Columbia, Missouri. "Their clinic was in the red for the month of March," he said. Other members cited the closing of satellite clinics and the shifting of care to hospitals.

Given that average selling price (ASP) + 6 does not take into account bad debt or the cost of pharmacy facilities, but does include the prompt pay discounts, most clinics are reimbursed less than the acquisition cost for the drugs. In addition, the severe reduction in payment for essential services has most clinics operating at a loss. Rep. Nancy Johnson cited one example, saying that as G codes were merged into C codes, some were meant to receive increased payments but were actually decreased. "For example, payments for colorectal cancer have declined very significantly from 2004 to 2006, down 36%."

Treatment access

The hearing also focused on the severe access issues to IVIG for immunocompromised patients. Congressman Mark Foley (R-FL) spoke with passion, saying "I came from a committee hear-

ing with my colleague Dave Camp, and we were talking about the esoteric nature of the tax code. Nobody's going to die over the tax code, but people are dying over access to IVIG, and I can't seem to get an answer."

Is access to IVIG a harbinger of what's to come in cancer care?

The Community Oncology Alliance (COA) proposed a number of solutions. Fred Schnell, MD, COA president, suggested we:

- eliminate the prompt pay discounts from the ASP calculation;
- remove the 6-month time lag in ASP;
- create payment codes for essential services—specifically pharmacy facilities and treatment planning—that Medicare currently does not have;
- restore appropriate payment for drug administration and address the reality of bad debt.

Much remains to be done. "Every clinic in the nation should engage its members of Congress and continue educating them about the realities of delivering quality, affordable, accessible cancer care," said Dianne Kube of COA. "That effort does make a huge difference. We have spent so much time with members of Congress, explaining the details of our issue. We're grateful that key members understand and are working to resolve the situation before it reaches the crisis level that we have seen with IVIG."