

Commentary

A way through: five tactics for fixing overcorrected reimbursements

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More Medicare reductions to reimbursement for cancer care are in the offing:

■ On January 1st, the 2006 quality oncology demonstration project is set to expire. Focused on the clinical decision-making of oncologists, the project contributed an estimated \$150 million to cancer care.

■ Community oncology is still saddled with a two-quarter time lag for adjustment in reimbursement associated with manufacturers' drug price increases. The total impact of the time lag is estimated at \$200 million per year.

■ The flawed definition of average sale price (ASP) that includes "prompt pay discounts" continues to drain up to \$200 million per year from community oncology.

■ The Centers for Medicare and Medicaid Services (CMS) is considering bundling pharmaceutical rebates, which could further reduce the actual ASP for certain drugs.

■ CMS is considering redefining codes that will further reduce payment for essential services.

■ Reductions in general fee schedules will lower reimbursement for evaluation and management, chemotherapy administration, and other essential services provided by cancer clinics.

■ The CMS 5-year work plan further ratchets down reimbursement per unit of service for cancer care.

■ Commercial insurers have joined the fray by incorporating the CMS model during contract renewals with providers.

What clinics are telling us

In 2006, 160 practices representing more than 500 clinic sites from more than 40 states responded to our surveys on patient access. More than 70% of respondents indicated significant patient volumes—in some cases more than 20% of their patients—were being shifted to hospitals or other healthcare entities every week.

They also reported:

■ Significant delays in care: (up to 7 days), as clinics try to work out replacement drug scenarios or alternative treatments

■ Patients in dozens of communities going without care when neither clinics nor local hospitals could provide help

■ Clinics having to close satellite as well as main offices. In one example, a practice in Iowa that had to close two offices was forced to send its patients to South Dakota for care

■ Staff layoffs. We heard from more than 100 clinics that are laying off staff or are not replacing people who have retired or left their jobs.

The five tactics

Solutions to fix the overcorrections to cancer care under the Medicare Modernization Act of 2003 (MMA) have been presented both legislatively

and administratively to CMS:

1. Legislative language that eliminates the prompt pay discount inclusion in ASP should be adopted from HR 4098 and S 2340 (The Ramstad-Specter) bills during the final Congressional negotiations with Medicare. These negotiations are meant to fix the sustainable growth rate (SGR) formula, which calculates physician payment on the Medicare fee schedule.

2. During its SGR fix, Congress should end the two-quarter time lag for reimbursement adjustments when manufacturers raise drug prices.

3. We need to create appropriate codes for pharmacy facilities and oncology treatment planning. This is what was intended under MMA. The language for these codes is included in the Ramstad-Specter bill and could be adopted during the SGR fix.

4. CMS should revalue the first and subsequent hours of chemotherapy, which are now paid substantially below actual cost.

5. CMS should also address the appropriate reimbursement for other services not covered, such as supportive care and the continuum of care, but provided by community clinics.

When Congress returns after the election, it is vital that its members hear from community oncologists.

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