Commentary

Congress puts a Band-Aid on Medicare

Ted Okon | Executive Director, Community Oncology Alliance

With only days remaining before Congress recessed for 2007, the Senate and House passed what can best be described as "minimalist" legislation on Medicare. The *Medicare, Medicaid, and SCHIP Extension Act of 2007* (S. 2499) averted the 10% cut to the Medicare physician fee schedule set to be implemented by the Centers for Medicare & Medicaid Services (CMS) on January 1, 2008. Instead, S. 2499 actually increased all physician-related Medicare payments by 0.5%. Unfortunately, this Band-Aid is only effective through June 30, 2008. Without further intervention, all physician specialties face Medicare reimbursement that will be cut significantly during the second half of the year.

Because this stopgap legislation was a vehicle for only a short-term solution to certain Medicare problems, it contained nothing of substance. As a result, none of the problems associated with Medicare Part B reimbursement for cancer care has yet to be addressed. Notably, they include manufacturer prompt payment discounts in the calculation of average sales price (ASP), lack of reimbursement for medical oncology treatment planning, and insufficient payment for pharmacy facilities to properly store medications.

Good intentions

The intent of the Medicare Modernization Act of 2003 (MMA) was to modify Medicare Part B payment for cancer drugs and services. Prior to MMA, reimbursement for drugs subsidized the significant underreimbursement for cancer services. It has now become clear to many lawmakers on Capitol Hill that MMA fell far short of the intent of the legislation to pay adequately and fairly for cancer care.

Unlike other discounts and rebates that can be realized by a community oncology practice, these prompt payment discounts between pharmaceutical manufacturers and wholesalers only decrease ASP and, therefore, reimbursement rates for cancer drugs. In effect, the payment rate of ASP + 6% is actually less than ASP + 4% with the inclusion of prompt payment discounts in ASP.

Stopgap measures

The goal of having CMS pay more adequately for cancer care services has not been achieved. Rather, CMS has only managed to stopgap the underpayment for essential cancer care services by providing oncology-related demonstration projects. Particularly notable: there is no reimbursement mechanism for medical oncology treatment planning. Even though CMS could create treatment planning codes that would ensure performance-based, quality cancer care planning—real, verifiable pay for performance—the agency shows no signs of doing so.

Realizing that only Congressional intervention will correct the deficits to Medicare reimbursement created by the MMA, the Community Oncology Alliance (COA) has worked closely with Senators Arlen Specter (R-PA) and Robert Casey (D-PA), as well as Congressmen Artur Davis (D-AL) and Jim Ramstad (R-MN), to support legislation in the Senate (S. 1750) and the House (H.R. 1190) This legislation addresses some of the obvious shortfalls in Medicare reimbursement for cancer care. In addition to eliminating prompt payment discounts from the calculation of ASP and creating medical oncology treatment planning codes, these companion bills would create a code for the payment of pharmacy facilities.

Before MMA, Medicare drug reimbursement covered the cost of maintaining pharmacy facilities, including the costs of pharmacy operations, inventory, storage, and waste disposal. However, this was eliminated by MMA and there is no payment mechanism for the increasing cost of maintaining pharmacy facilities.

As Congress returns from recess in the middle of this month, it will be forced to take up Medicare legislation to address the Band-Aids it has applied. This will include a more permanent, realistic fix to the inherent problems of a Medicare payment system based on the flawed concept of the sustainable growth rate (SGR). The SGR-based system is not viable because it does not address the reality of an expanding Medicare population and the increasing cost of medical technology.

S. 1750 and H.R. 1190 provide community oncology with an excellent opportunity to improve Medicare policy. Support has grown in Congress to fix some of the Medicare reimbursement problems associated with cancer care. COA will be working with community practices to engage their members of Congress early this year. The old maxim is especially true on Capitol Hill: "The squeaky wheel gets the grease."

Mr. Okon is Executive Director of the Community Oncology Alliance, based in Washington, DC.

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