New Medicare Bill Targets Discrepancies in Fees for Cancer Drugs, Outpatient Services

The oncology community was sent reeling in late November after Congress passed, by the thinnest of margins, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, a bill that sought to provide a prescription drug benefit for seniors.

To make fiscal room for these benefits, which are scheduled to be in place by 2006, the bill mandated cuts in the current Medicare drug payment system. Some legislators with influence on the final draft of the bill chose to focus on the longstanding, lopsided system that overpays oncologists for chemotherapy drugs while chronically underpaying drug administration expenses. Many oncologists felt that this reimbursement cushion was needed to counteract serious shortfalls in Medicare payments to the private oncology clinics, which have become the main providers of cancer treatment and whose costs for treating patients has risen steadily.

Despite intense lobbying by oncology organizations, support groups, and industry, however, the bill that emerged in the middle of the night on November 21 was embedded with provisions within its 700-plus pages that deeply slashed that cushion—$11.5 billion over the next decade—with a promise of far lower increases to practice expenses. As it stood, oncologists would lose money on both drug reimbursements and practice expenses.

Only a last-minute revision, put out December 31 by the Centers for Medicare & Medicaid Services (CMS) and published in the Federal Register January 7, provided some general relief for private oncology practices in 2004, increasing some fees associated with drug administration by up to 400% in 2004, but the temporary gain is “just postponing the pain,” said Deborah Kamin, senior director for cancer policy and clinical affairs at the American Society of Clinical Oncology (ASCO).

“We forestalled some huge cuts this year, but we are still very concerned about 2005 and beyond,” said Kamin. “Still, we have this year to work with Congress and the administration to correct the shortfalls scheduled for 2005.”

But some oncologists are not waiting to see what will happen next year. They have already concluded that, despite the interim adjustment by CMS, they will now have to pay out of pocket for a number of common chemotherapy treatments, and so have started sending their patients to hospitals to receive chemotherapy treatments. Some rural satellite clinics are reportedly planning to close, and oncology leaders predict that the new bottom-line mentality forced on small clinics through the new legislation will affect care.

“This is a huge nightmare,” said Dean Gesme Jr., M.D., of Oncology Associates of Cedar Rapids, Iowa. “When you are dealing with no margin by definition in law, to suggest oncologists make no changes in their practice is naive at best.”

Said Gesme, who serves on ASCO’s Clinical Practice Committee, “The bill does nothing but offer incentives that erode the quality of care.”

Historically Lopsided

When the Medicare Act was passed in 1965, most cancer patients were treated in the hospital, with a repertoire of less than a dozen drugs complemented by radiology and surgery. Care for these patients was reimbursed under the more generous Part A Medicare funding for hospital care; there were no outpatient cancer treatment facilities supported by Part B funding, which is intended to cover less intensive clinic care.

Today, however, ASCO estimates that more than 80% of all cancer care in the country is delivered in private oncology clinics, not in hospitals. Of the 1.2 million patients newly diagnosed with cancer each year, about half are of Medicare age, and of those, up to 70% will receive chemotherapy, the organization said. That means that roughly 420,000 Medicare patients begin chemotherapy treatment every year, primarily in private clinics.

But the Medicare system has had little flexibility built into its system for paying for what now constitutes outpatient treatments for cancer. The original legislation paid for drugs that were infused into a patient (similar to ones used in a hospital) and so covered chemotherapy and associated drugs delivered intravenously or under the skin, but the mechanism contained little way to pay for costs associated with administering these drugs (such as skilled nursing help, strict handling requirements, and patient counseling) if they were not delivered in a hospital.

As cancer care moved from hospitals to outpatient clinics, the Health Care Financing Administration (the precursor to CMS) solved the reimbursement issue by paying more for chemotherapy drugs than they cost, implicitly allowing the clinics to use the margin to cover administration of the drug. “The case has been for some time that Medicare pays only about one-fourth of what it costs to actually deliver the drug to patients,” Kamin said. “That includes the oncology nurses, the social workers, the nutritional counselors and all those services needed to support the patient through a chemotherapy experience.”

To compensate, Medicare paid 95% on average wholesale price (AWP), which is an unregulated list price reported by drug manufacturers. The issue of cancer drug overpayment
became both public and political fodder several years ago when Congress examined the rising cost of health care. Government auditors found that oncologists typically pay only between 66% and 87% of AWP and concluded that Medicare overpayments for cancer and other drugs cost taxpayers more than $1.6 billion a year. An example of abuse widely cited by the Bush administration was the price of leucovorin calcium, used for treating colon cancer, which lists for $18.44. Medicare pays 95%, or $17.52, but some physicians can buy it for $2.77.

In August 2003, CMS indicated that it would work to cut Medicare payments for cancer drugs, and oncologists began to worry that the move would siphon money from cancer treatment to pay for a new Medicare prescription health care plan without adequately increasing physician fees.

The bill that passed did just that. It dropped reimbursement for drugs to AWP minus 15% in 2004, a reduction that CMS estimated will save more than $510 million this year. Starting in 2005, payments will be based on a new formula, average selling price (ASP) plus 6%, but no one knows yet what ASP is, said Kamin. The bill also called for the temporary increase inpractice expense payments to begin dropping off in 2005.

Although lobbying by the cancer community had some effect, “people had their heels dug in to their point of view. It was very disappointing,” said former Senator Connie Mack, who lobbied on behalf of US Oncology, a corporation whose affiliated network of oncology physicians cares for approximately 15% of all newly diagnosed cancer patients each year in the United States.

**Affecting Rural Access**

Despite the increased CMS administration fees, the largest cancer treatment practice in Louisiana, Hematology-Oncology Specialists, which sees 6,000 new patients a year (half of whom are Medicare patients), had shut six of its 10 locations by mid-January. And they are already sending patients to the hospital to receive chemotherapy drugs who they know will cost the practice more than it can afford, said Owen Dahl, chief executive officer of the 23-physician practice. “We have a net loss this year in treating these patients, and we are still very concerned about 2005,” said Dahl. “All of our patients are being affected by this bill. They either have to travel farther to one of our remaining four locations, or they have to go to the hospital. And all we get from Washington is that we abused the system.”

By such accounts, the prediction that rural access to chemotherapy clinics would fall sharply, as practices closed satellite offices that had suddenly become unprofitable, seems to be coming true. The irony, experts point out, is that if patients are forced to seek care in costly hospitals that are already overburdened, the end result will be that cancer care will be even more expensive than it is today. And it would be much less convenient to the patients who had expected that the new bill would be a boon to them.

Instead of expanding access to lifesaving drugs, the bill would limit access to cancer treatments for some of the most seriously ill Medicare patients, said Bill Schmidt, of the National Coalition for Cancer Survivorship, an advocacy group led by cancer survivors.

US Oncology agreed that private oncology services would be seriously affected, and issued a statement in December saying that its net income would likely be reduced by approximately 30% as a result of reduced drug payments and practice fees that did not cover costs. After that announcement, its stock fell 13%.

“Small practices, those with a few oncologists working together, are going to be devastated,” said Lloyd Everson, M.D., US Oncology vice chairman of the board of directors. “In any business you know of, who can sustain significant cuts without doing something to ratchet back and cut the services they provide?”

The CMS ruling that increases some fees associated with drug administration by up to 400% would, according to CMS, provide a “wash” between drug cuts and physician fees in 2004. But some oncologists dispute that, saying that they are being forced to pay more now for some key chemotherapy drugs than Medicare will reimburse them for.

“2.77, in my math and in that of others that I have talked to, it isn’t a wash,” said Gesme, whose Iowa practice includes five physicians and four satellite clinics.

Physicians in Massachusetts are already attempting to send their patients to hospitals for chemotherapy treatment, but hospitals are resisting and patients are left waiting for their treatment, said Terry Mulvey, M.D., president of the Massachusetts Society of Clinical Oncologists. In the society’s analysis, such major chemotherapy drugs as carboplatin, oxaliplatin, and rituxan, as well as gemcitabine, will be reimbursed by Medicare at less than what physicians can purchase them for in 2004.

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**Changes in Medicare Payments for Drug Administration Services**

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“The current Congress and CMS decided [that] oncologists must be making a fortune, but they looked at one side without adequately examining the other,” she said. “Oncologists are now being asked to subsidize their patient’s care, but it is the patients I feel most badly for. They may now have to schlep around for their care, and that is not the kind of seamless attention they deserve.”

The University of Texas M. D. Anderson Cancer Center, for one, expects such “nomadic” Medicare patients in the Southwest to start seeking care there soon, and although they have the capacity to help, a huge influx might become an economic concern, said the cancer center’s chief financial officer Ben Melson. Medicare funding for patients seen at M. D. Anderson is less than what, say, a typical health maintenance organization pays, so if the share of Medicare patients grows from the 29% treated there today to 35% to 50%, “that could put more financial stress on us,” Melson said. “We would not turn them away, but the situation could become inconvenient for us as well as for the patients, many of whom might have to travel to get here.”

Some Gains

Still, gains were made in the new Medicare bill that will offer patients benefits they did not have before. The government will now cover the initial visit and a physical examination within 6 months of their enrollment in Medicare, and this “will help promote prevention and early detection and will result in lives saved and improved quality of life for seniors,” said Wendy Selig, vice president of legislative affairs for the American Cancer Society.

Additionally, there is now some coverage for oral chemotherapy drugs, such as tamoxifen and Gleevec, which was not available before. As of April 2004, $200 million will be available so that some Medicare patients will have transitional coverage for these drugs until the bill goes into full effect in 2006. Even so, participation in this program is limited to residents in only six states—which are as yet unidentified—and is capped at 50,000 patients.

Providing some compensation for oral chemotherapy drugs was the major emphasis of a number of cancer support groups, such as the National Breast Cancer Coalition. Although some of that benefit was realized, more might have been achieved if ASCO and other groups had lobbied as much for the issue as they did for practice expense reimbursement, said Fran Visco, president of the National Breast Cancer Coalition. “They were focused so much on the average wholesale price issue that [oral drug coverage], unfortunately, wasn’t treated as a priority.”

Visco further pointed out that the old system that reimbursed oncologists for exaggerated drug prices resulted in unfair, inflated co-payments billed to Medicare patients—a criticism that Gesme agrees with. “It’s been clear for years that oncologists were getting paid more than they should have for drugs, and everyone was playing along with that, from industry and the government to the oncology community. But that adversely impacted patients in terms of their increased co-payment, and that is what concerns us,” Visco said.

The American Cancer Society’s lobbying efforts also focused on providing an oral drug benefit in addition to the preventive office visit, “and on those two points we feel we did pretty well,” said Selig. But the overall bill still leaves the oncology community in jeopardy, she said. “This is not the Medicare bill that the American Cancer Society, or any of us, wanted.”

—Renee Twombly