Community Oncology Alliance

DEDICATED TO EXCELLENCE IN CANCER CARE IN THE UNITED STATES

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Community Oncology Alliance (COA) Position Statement

Effective January 1, 2005, there are scheduled historic, fundamental changes to Medicare Part B reimbursement for cancer care. First, the reimbursement for cancer drugs will change from the AWP-based (Average Wholesale Price) system to one based on Average Selling Price (ASP). Under the AWP system, community cancer clinics were over-reimbursed for cancer drugs because this subsidized the under-reimbursement for essential cancer care services (i.e., payment for the administration of chemotherapy, nursing care, patient monitoring, and other care services required by cancer patients). Second, the reimbursement for essential cancer care services is scheduled to decrease by 29 percentage points (the 32% 2004 increase for services reimbursement decreases to 3% for 2005).

Although the changes are a step in the right direction to balanced Medicare reform, the ASP-based reimbursement system is a *conceptual* system that has never been analyzed and/or implemented before by CMS. This system is totally unknown and is being implemented without a safety net.

One of the key issues is that the ASP system has inherent definitional and structural problems that must be addressed in advance of its implementation on January 1, 2005. Implementing an ASP-based system without the proper modifications and safeguards threatens the viability of community cancer care for seniors covered by Medicare because drug reimbursement is projected to be less than actual costs. This assertion is based on extensive market analysis of preliminary estimates of ASP just released by CMS.

A few of the key problems with ASP are as follows:

- ASP is not a market price available to community cancer clinics; it is a price paid by large drug purchasing intermediaries that inventory/resell drugs to clinics.
- ASP as defined is an unstable price that will vary quarterly because it is subject to the buying of these large intermediaries. This will cause reimbursement rates to be unstable and vary, resulting in an operational nightmare and financial burden for cancer clinics.
- There will be a 3-6 month lag in reporting/processing ASP, which means that price increases for cancer drugs will not be reflective in reimbursement rates in a timely manner. Cancer clinics will be getting reimbursed less than their cost for cancer drugs.
- The reimbursement rate of ASP + 6% does not cover all the direct drug costs (e.g., inventory, pharmacy, storage, waste) incurred by cancer clinics.

The argument is made that cancer patients are overpaying for cancer drugs. Patients have overpaid the co-payment for drugs but have significantly underpaid (or did not pay) for services. If the AWP system were better balanced, as community oncologists have been arguing for years, patients would have still paid the exact same amount because the 20% co-payment is levied by Medicare on all cancer care treatment. The fact is that many

patients' co-payments are not collected by community cancer clinics because patients cannot afford this onerous tax.

The Centers for Medicare and Medicaid Services (CMS) estimates that the scheduled Medicare reimbursement changes will reduce reimbursement for cancer care by over $500 million. COA estimates that the reduction will be over $900 million. The difference lies in the fact that CMS has only ASP data for a partial list of cancer drugs. COA has used market data to estimate ASP 2005 reimbursement for all cancer drugs.

Many Members of Congress and CMS realize the problems facing cancer care in 2005 and have been working with the cancer community on solutions. COA has been providing lawmakers and administrators with market data drawn from community cancer clinics around the country. For example, a COA-initiated task force of 18 experienced cancer clinic administrators recently produced a report of specific findings and recommendations related to services reimbursement. This report was provided to Members of Congress and CMS. Additionally, cancer clinics have been reaching out to their Members of Congress, inviting them to their facilities to sit in an actual chemotherapy chair and to learn more about the realities of delivering modern-day cancer care. The experience shows the complexity of treating cancer and the escalating cost of drugs and services.

Cancer survival rates have increased significantly, with a corresponding decrease in the death rate over the past 30 years, according to the *Annual Report to the Nation on the Status of Cancer*. During this time period there has been a major shift where cancer is treated to community-based, private cancer practices, where now over 80% of Americans battling cancer are treated. Being able to be treated close to home, with less cost and disruption, has been a boom for cancer patients, which coupled with earlier detection and better therapies has helped produced dramatic results on the war on cancer.

COA believes that Americans' access to quality, affordable cancer care must not be jeopardized.

The COA position is that the problems with the ASP-based system must be addressed, as well as the substantial cut in cancer care services reimbursement. There is no rationale for substantially decreasing the reimbursement of cancer care services effective January 1, 2005 when the cost of administering chemotherapy and providing cancer care is at least increasing by 4% per year, the general increase in medical services as measured by the CPI-Medical. The logic is inescapable that there should at the very least be a transitional payment mechanism in place for 2005, while current and new systems are run in parallel, with a safety net based on 2004 payment. This will allow for more data to be collected and analyzed by CMS; studies mandated by MedPAC, OIG, and others; and more data and information from the cancer community.

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