

## State of Cancer Care After Medicare Reimbursement Changes: April 2005

- MMA reimbursement changes are a step in the right direction but fall short of adequately paying for modern-day cancer care. Ironically, the unintended consequence of these changes is the potential to actually increase the cost of cancer care to Medicare and cause patient access problems. The late 2004 addition of the \$300 million CMS demonstration and other funding additions to Medicare averted a cancer care crisis in 2005. However, private insurers announcing cuts as early as July 2005 in parts of the country and scheduled Medicare cuts effective for 2006 are two cliffs facing community cancer care.
- Important cancer drugs are now reimbursed less than cost. Updating the Government Accountability Office (GAO) report of 12/1/04 (regarding the adequacy of Medicare drug reimbursement) with actual 2<sup>nd</sup> quarter reimbursement rates, reimbursement is below GAO cost by \$85 million for the 16 cancer drugs analyzed by the GAO and \$113 million below for all cancer drugs.
- Factoring in bad debt reality (patients unable to pay Medicare co-insurance), based on the GAO analysis, 13 of the top 16 cancer drugs are being reimbursed by Medicare at a rate lower than cost.
- An unintended consequence of the MMA is to make a cancer clinic's routine use of certain drugs "cost prohibitive." This threatens higher costs for Medicare as oncologists are forced either to choose equipotent, equitoxic drugs that cost more or to send patients to the higher cost hospital setting for treatment to avoid incurring untenable financial losses that will close a medical practice.
- Pharmacy functions directly related to cancer drugs (e.g., storage, inventory, waste disposal) are now not adequately reimbursed and payments have not kept pace with the increasing complexity and requirements of properly storing and handling these potentially toxic drugs. MedPAC released preliminary findings that pharmacy facility costs can be 27% of total drug costs, with drug acquisition costs accounting for 73% of the total.
- Medicare does not reimburse community cancer clinics for the extensive planning required to treat cancer patients. Providing medical care to a person with cancer requires an individualized treatment plan tailored to the patient's diagnosis, overall medical condition/history, age, and disease prognosis. CMS already reimburses radiation oncologists for treatment planning but, inexplicably, not medical oncologists.
- Actual Medicare changes to cancer care reimbursement are exceeding congressional intent. Congressional intent inherent in the MMA is for \$2.5 billion to be cut from Medicare funding for cancer care over a ten-year period. However, according to a study by PricewaterhouseCoopers based on actual, current Medicare reimbursement rates, \$9.7 billion will actually be cut over the identical period. Community cancer clinics cannot absorb cuts of this magnitude.
- CMS must act immediately to protect access to high quality, affordable cancer care by taking the following steps:
  - Fix ASP. (Increase Medicare reimbursement for cancer drugs where the reimbursement rate is lower than costs; increase reimbursement immediately for drugs with price increases; and eliminate prompt pay discounts from the ASP calculation.)
  - Create a treatment planning code for medical oncology, as currently exists with radiation oncology.
  - Create a pharmacy facilities fee to pay for direct drug costs (e.g., storage, inventory, pharmacy, waste disposal).
  - Extend the CMS demonstration project that monitors critical cancer symptoms.

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