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The Truth About Fair Reimbursement

Just recently the question of what is a fair reimbursement to provide to physicians for chemotherapy has been resurrected. The Office of the Inspector General (IG) took the first shot at physicians in a study released on December 5, 1997. In that report, the IG reviewed payments made by Medicare for chemotherapy drugs, the average wholesale price published in the *Redbook* for those same items, and an average of what the purchase price for those drugs would be from a number of wholesale drug outlets. The IG concluded that the savings for drug cost outlay on twenty-two drug codes for 1996 would have been $447 million had the cheapest of the drug outlet prices been used, and $337 million had more expensive wholesale outlet prices been used. However, the IG failed to evaluate service, delivery time, minimum quantities, or return policies when these results were compiled. Furthermore, the report overstates the Medicare program savings by implying that Medicare pays the entire cost of a drug, when in reality it pays only 80 percent of the drug cost.

Is it not fair to expect the IG to look at the *entire* cost of providing the drug to a Medicare beneficiary and not just the drug price? Such additional costs for chemotherapy administration include the purchase price as well as costs for drug ordering, storage, and drug waste disposal, in addition to the capital used to stock a readily available supply of anticancer drugs in the oncologist's office. Certainly the IG's report would be far less politically exciting if the IG had measured the real acquisition cost.

The Wall Street Journal sensationalized the IG's report in its December 8, 1997, edition. The *Journal* failed to study this complex issue in depth, and thus never learned that there is more to making these services available than just ordering a drug. Five days later President Clinton announced on his weekly radio address that his administration was going to crack down on physicians committing Medicare fraud, including those doctors who charge too much for chemotherapy. Although physicians bill the Medicare program in accordance with the law, this activity has now been redefined by our Chief Executive as a form of fraud.

On the surface the President and the media appear righteous and all physicians avaricious. However, the lack of attention to the real issues at stake suggests to me an unfortunate example of truth and fairness lost in favor of a good political story.

The Health Care Financing Administration gladly accepted the IG's report and stated that HCFA "will continue to work on the situation." HCFA Administrator Nancy-Ann Min DeParle did not bother to mention anything about the other parts of the chemotherapy issue. She failed to comment on the fact that HCFA analysis, repeated twice, has shown that the cost for delivering chemotherapy to a patient for one hour is $173, but that HCFA pays the oncologist only $60 for this service. DeParle neglected to comment that, when administering cancer chemotherapy, many oncologists must pay their state and local governments a sales tax, an amount ignored in the IG study. Finally, there was no mention of the impact on an oncologist's practice if Medicare changes the chemotherapy reimbursement system to one where the oncologist cannot cost-shift bad debt or late payments. How is it fair to scapegoat physicians when this vital information continues to go unreported?

Putting all fairness aside, there are several good reasons for supporting the 95 percent of AWP method that Congress enacted last summer. First, the method provides a level of reimbursement for drugs that allows physicians to cover the additional costs of service such as ordering, stocking, and disposing of biologically hazardous material. It has provided enough reimbursement to allow cancer specialists to continue to treat patients in their offices, even though those same doctors are receiving from Medicare only 25 to 35 percent of the chemotherapy administration cost. Finally, if those same anticancer chemotherapy delivery services were moved out of the doctor's office and into a hospital outpatient clinic, the *increased* cost to the Medicare program would be in the billions. This additional cost would arise from the fact that the entire payment structure for outpatient hospital services derives from the Part A Medicare trust fund, not Part B, which is the source for most office-based treatments at this time. These points illustrate that settling political scores may come at great cost to the American public.

In truth, the Administration displays no fairness about this issue. Hopefully, the elected representatives to Congress will retain the wisdom they displayed last year and work with all of us to ensure that Medicare beneficiaries have ready access to the treatments they need. Let's try to protect the elderly from falling victim to these political maneuvers and keep all our legislators informed about how important access to adequate cancer care really is. Let us be the ones who are truly fair.