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Acquisition Cost Proposals: The End of Community-based Cancer Care?

by David H. Regan, M.D., and Charles H. Weissman, M.D.

Excerpts from "The Impact of Medicare Payment Policies on Patient Access to Quality Cancer Care" by Barton C. McCann, M.D., and Julia A. James, June 1999.

For the third time this year alone, President Clinton has issued a proposal that could put an end to one of the great victories in America's War on Cancer: the expansion of community-based cancer care. As he did in his Fiscal Year 2000 Budget and a May 1999 budget message to Congress, the President included in his Medicare reform plan a proposal to further limit Medicare payment for outpatient drugs by setting the reimbursement level at average wholesale price (AWP) minus 17 percent.

While Medicare does not generally cover outpatient prescription drugs, a large proportion of the outpatient drugs that Medicare does cover are chemotherapy agents used to treat cancer. As a result, the President's efforts to reduce Medicare reimbursement are of particular importance to America's cancer care community.

To determine the full impact of AWP minus 17 on cancer patients and providers, Barton C. McCann, M.D., and Julia A. James were asked to conduct a comprehensive analysis of Medicare payment policies for cancer care. McCann served for twenty-two years in the Commissioned Corps of the U.S. Public Health Service. From 1986 to 1998, he was the senior medical officer of the Health Care Financing Administration's Policy Bureau, where he was actively involved in the development and implementation of the Medicare fee schedule for physicians' services. James served for eight years on the staff of the Finance Committee of the United States Senate where, as the chief health policy analyst, she oversaw federal legislation relating to the Medicare program. Today, McCann and James serve as principals of Health Policy Alternatives, Inc., a legislative and regulatory analysis firm in Washington, D.C.

Their findings are nothing short of chilling. The following are excerpts from their analysis, as well as a table illustrating the impact that AWP minus 5 percent is having and that AWP minus 17 percent would have on the cancer community.

"Over the last forty years, the arsenal of therapies available to treat cancer has improved dramatically. Cancer is no longer considered a terminal disease, but rather a treatable and survivable illness. Cancer care can be provided in hospitals on an inpatient or outpatient basis, or in non-hospital settings such as physicians' offices and clinics. Treating cancer patients in physicians' offices is lower in cost than hospital-based treatment. However, the cost of physician office-based cancer care is higher than the cost of treating other conditions in a physician's office because it requires a team of specially educated physicians, nurses, pharmacists, and social workers, as well as special equipment and supplies. To meet their patients' needs, cancer care teams must offer extended hours of service and around-the-clock availability to patients and their families. The availability of physician office-based cancer care is dependent on adequate payment for the services provided and the drugs administered.

"For services provided to cancer patients in physicians' offices, Medicare pays physicians according to the Medicare resource-based relative value scale (RBRVS) fee schedule. These payments are intended to cover the costs of professional care, practice expenses (direct and indirect), and malpractice insurance expenses of the treating physicians. Unlike Medicare payment for hospital-based care, no separate "facility fee" is paid for office-based services. Reimbursement by Medicare for the chemotherapy and related drugs administered in physicians' offices is limited to the average wholesale price (AWP) minus 5 percent. President Clinton has proposed to lower that payment limit to AWP minus 17 percent.

"An analysis of the potential impact of the proposed reduction of Medicare drug payments on oncologists' practices was per-

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formed using 1998 utilization data obtained from an actual seven-physician oncology practice (which is believed to be representative of physician office-based cancer practices). Medicare revenues that would be generated for the services and drugs provided were determined by applying 1999 Medicare allowable payment amounts for professional services and covered drugs. Costs for providing the professional care were calculated by applying the cost data used by HCFA to develop the practice expense component of the RBRVS fee schedule. Drug costs were calculated using the OIG estimates of the average amounts paid by physicians for the chemotherapy and supportive drugs. Medicare related revenues and costs were then compared under three scenarios: the pre-1998 payment policy of 100 percent of AWP; the current policy of AWP minus 5 percent; and the proposed policy of AWP minus 17 percent.

"Three key findings emerged from the analysis of these data: Medicare payments under the RBRVS fee schedule for cancer care, particularly for drug administration services, are dramatically lower than the direct and indirect costs of providing the care. Surpluses generated by the current level of drug reimbursement (i.e., AWP minus 5 percent), are not sufficient to overcome the underpayment for professional services, and the result is a net loss per Medicare patient.

The proposed reduction in drug payments to AWP minus 17 percent eliminates virtually all of the excess practice compensation attributable to current Medicare drug payments that would otherwise be available to offset the losses under the physician fee schedule. As a result, losses incurred in treating Medicare cancer patients would be even greater than they are now.

"The Summary Table presents the annual Medicare-related net practice compensation under AWP, AWP minus 5 percent, and AWP minus 17 percent for the sample physician practice studied. It clearly demonstrates that the practice incurs significant losses for drug administration and that the losses are only partially offset by compensation for the drugs themselves. If drugs were paid at the full AWP, as they were prior to 1998, the annual Medicare related practice compensation would be $149,865. This translates to $166 for each of the 902 Medicare patients treated. Under the current policy of AWP minus 5 percent, the annual Medicare related practice compensation becomes a loss of $162,058, and a per Medicare patient loss of $180. If the proposed policy of AWP minus 17 percent were to go into effect, the losses become significant with the practice potentially losing $910,680, or $1,010 per Medicare patient.

"In light of the discrepancy between Medicare payments and the costs of oncologists' services, the proposed reductions in drug payment pose a significant risk to the viability of physician office based cancer care. Until the present time, the additional practice revenue generated under the AWP or the AWP minus 5 percent methodology for drugs has enabled these practices to remain open by subsidizing the expensive amount of coordinated care that cancer patients require.

"If the proposal to reduce drug payments to AWP minus 17 percent is implemented, we foresee at least three major consequences. First, Medicare beneficiary access to cancer care in physicians' offices will be substantially reduced. While it is possible that some existing practices could survive for several years by shifting costs to private payers, the current health care marketplace makes such cost-shifting increasingly difficult. It is also unlikely that new practices would open. Second, the total costs to the Medicare program could rise if patients responded to the impact of AWP minus 17 percent by receiving their care in the more expensive hospital setting. In this regard, it is important to note that HCFA's proposed rule for a hospital outpatient prospective payment system published in the *Federal Register* on September 8, 1998, could also lead to increased admissions as a result of inadequate payments for cancer care in the outpatient hospital setting. Third, access to many of the newer, more effective cancer drugs by Medicare beneficiaries could be restricted since most are single-source drugs with high costs, minimal or no discounts below the AWP, and no generic equivalents."

Given McCann and James' findings, it is clear that the Administration and Congress must not reduce Medicare's support for cancer care. Instead, the program's reimbursement of practice expenses must be given the review and correction that have been long overdue. ■