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Of AWPs and APCs

by Christian Downs

The Health Care Financing Administration (HCFA) has proposed to redefine average wholesale price (AWP) by substituting a Department of Justice survey for *Red Book* pricing on 16 oncology drugs. HCFA has said it would like to implement this proposal on or about October 1, 2000. HCFA is also putting pressure on the *Red Book* and on First DataBank to change AWP to a lower number, which they refer to as "manufacturer's list" price. In a lengthy letter to Chairman Tom Bliley of the House Commerce Committee, Donna Shalala, the Secretary of the Department of Health and Human Services, said the department has other plans to decrease the margin available to providers. While most communications from DHHS, HCFA, and members of Congress have noted that oncologists and cancer drugs deserve a "bump" on top of this price, no moves have been made to institute any restitution of the loss to practices and hospitals.

ACCC and a number of other groups are analyzing the effect of cuts on hospitals and practices. While we do not yet know the size of all of the cuts being proposed, the 50 drugs in the initial Department of Justice (DOJ) report, including 16 oncology drugs, are commonly used multisource drugs. Moreover, a quick survey of hospitals and oncology practices indicates that many of the prices in the DOJ survey are below readily accessible acquisition costs by oncologists and hospitals.

ACCC had The Lewin Group and Orion Consulting review HCFA's own Medicare database in preparation for last year's debate on the Balanced Budget Refinement Act (BBRA). When drug costs were analyzed, including the hospital's pharmacy mix charges, inventory carrying costs, wastage, and spillage, the number was *equal* to AWP minus 5 percent. Thus, if there is a cut in AWP (or it is changed to some other number without a margin to compensate hospitals for their overhead costs), hospitals will immediately begin to lose money on outpatient cancer care delivery. The new APCs do not adequately compensate hospitals for chemotherapy administration (it's basically a break-even proposition), so losses on drugs will undermine the congressional fix of last fall and hospitals will end up closing their outpatient cancer programs. This was and is not Congress' intent, but it could easily happen by HCFA's unilateral redefinition of AWP.

At the same time, medical oncology offices are where 60 percent of all chemotherapy is delivered. A number of studies have shown that costs for delivering care to Medicare patients is underreimbursed, even before any of these proposed cuts are implemented. Thus, with the large number of staple oncology drugs potentially being given lower reimbursement rates, it is highly likely that many oncology offices will face devastating economic consequences. Given the losses they could experience every time they treat Medicare patients, it is likely that some practices will agree to have a physician see Medicare patients and give them a script for their therapies. But if both physician offices and hospital outpatient areas are closed, where will these patients receive their drugs?

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ON THE APC FRONT

Facing concerns by providers and internal application problems, HCFA has delayed the implementation of the hospital outpatient prospective payment system (HOPPS) until August 1, 2000, at the earliest.

The main problem HCFA faces is the development of its Claim Expansion and Line Item Processing form (CELIP). This is the expanded claim form necessary for the new payment system. HCFA had proposed releasing the form on April 1 for hospital review and training, but information system delays prevented the release of an accurate and functional form. HCFA has instructed fiscal intermediaries, the companies that process hospital claims, to continue to train hospital outpatient departments on implementing the system through July. At the same time, according to HCFA, during July hospitals will be paid using mostly the cost-based system the HOPPS will replace.

What remains unclear is how hospitals will be paid for providing outpatient services if problems develop once the HOPPS is implemented. In a contingency plan released May 23, the agency said if a delay is necessary, it would pay providers 70 percent of Medicare's share of the payment, which is generally half their total payment. HCFA should release a complete plan on how hospitals should be paid in the next several weeks.

Meanwhile, it is critical that cancer program administrators and physicians prepare for the HOPPS to protect the cancer service line. Administrators should make sure their superiors understand the unique situations faced by the cancer service line under HOPPS and that it may take the cancer program longer than other departments to show results under this new system.