Oncology Issues

ISSN: 1046-3356 (Print) 2573-1777 (Online) Journal homepage: https://www.tandfonline.com/loi/uacc20

Well, What's Next?

David H. Regan

To cite this article: David H. Regan (2000) Well, What's Next?, Oncology Issues, 15:6, 5-5, DOI: 10.1080/10463356.2000.11905164

To link to this article: https://doi.org/10.1080/10463356.2000.11905164

Published online: 17 Oct 2017.

Well, What's Next?

Following intense reaction from the cancer community (including patients, patient advocacy groups, oncology nurses, oncologists, and members of Congress), the Health Care Financing Administration (HCFA) withdrew its proposal to drastically cut payments for 17 drugs primarily used to treat cancer and hemophilia. HCFA had proposed that carriers pay Medicare claims using the Department of Justice (DOJ) compiled data. The DOJ payment rates were below prices that most providers would have to pay for the drugs. However, in a sudden turn around, HCFA instructed carriers on September 8 *not* to use the DOJ data source in determining payments of Medicare claims for those specific 17 drugs, but rather use their usual source of average wholesale prices for chemotherapy drugs and clotting factors. The cancer community is quite thankful for HCFA's recent decision, thus ensuring those Medicare beneficiaries with cancer continued access to needed care.

The cancer community is also very grateful for the strong support from members of Congress, which was central to the HCFA leadership retracting its risky proposal.

In the September 8 HCFA communication, the agency's former Administrator Nancy-Ann Min DeParle affirmed that HCFA is prepared to take the right approach in addressing Medicare payments for drugs. Medicare would pay correctly for the drugs, assuring adequate payment for services related to providing the drugs as well as administering the drugs to patients. HCFA admits that the current payments for chemotherapy administration are inadequate and need to be increased. The goal would be "to have more accurate pricing for both chemotherapy drugs and chemotherapy administration in place at the same time," DeParle said. HCFA also agrees that hemophilia drugs need an "administrative fee" to cover the costs of shipping, storage and inventory control. The same is true for covering expenses for providing chemotherapy drugs, including but not limited to, shipping, storage, wastage, spillage, spoilage, and special unique expenses associated with taxes, billing, and collection.

Given HCFA's new understanding as written in the September 8 HCFA communication, a solution to this problem would seem to be reachable. The two issues that need to be addressed are the RVUs (relative value units) for chemotherapy and other associated infusion therapy codes, and the correct price for drugs. First, HCFA possesses the reference inputs for chemotherapy infusion. These inputs were developed for HCFA at taxpayer expense through the Clinical Practice Expert Panel (CPEP) process, subsequently validated by HCFA using additional physician panels, HCFA officials, and Medicare carrier medical directors. The inputs were then approved by the American Medical Association Relative Value Unit Committee (AMA/RUC) and resubmitted to HCFA in the legislatively mandated "refinement" process for determining practice expense RVUs for certain codes, including chemotherapy administration. HCFA would just need to take the direct cost inputs, which equal 37.2 percent of the total, add to it the indirect cost factor of 62.8 percent, and then arrive at appropriate RVUs for chemotherapy administration. Currently, the RVUs are less than 25 percent of what they should be. Using the relative value approach, the other codes in the infusion family could also be appropriately related. HCFA could do it without using a lot of additional taxpayer money.

Second, accurate drug pricing needs to reflect all the expenses of providing the chemotherapy drug to the patient. The drug pricing would include the manufacturer's "list price," which would reflect that price available to the smallest purchaser plus an administrative fee to cover the cost of storage, shipping, inventory, wastage, spoilage, spillage, and other related expenses. These unique costs for providing chemotherapy and hemophilia drugs are not covered by technical codes for the administration of the agents, and I am pleased that HCFA has acknowledged their importance in the September 8 communication.

Finally, the fact that HCFA has agreed that chemotherapy is underpaid vindicates the provider community of the drug profit fraud and abuse charges leveled by the Clinton administration for the past several years. In fact, the underpayment of chemotherapy administration of the 17 cancer-related drugs in the DOJ report measured in real dollars far exceeds the total dollars in the margins paid by HCFA for these same drugs. Whether they realize it or not, most oncologists lose money when treating patients with these 17 drugs at current AWP minus 5 percent for drug and chemotherapy administration payments.

Now is the time for the cancer community, including patient advocacy groups such as the American Society of Clinical Oncology, Oncology Nursing Society, and Association of Community Cancer Centers to work together with HCFA and Congress to bring clarity to the financial support of the cancer care delivery system.

David H. Regan