The US Oncology Network
Health Policy Report

Thursday, May 31, 2012

Help Ensure Accurate Reimbursement for Cancer Drugs

Encourage Support for Prompt Pay Legislation

While Congress gears up for another election year, it is important to remind them of the disparity in cancer care reimbursement. In 2003, Congress established the Average Sales Price (ASP) as the reimbursement metric for drugs reimbursed under Medicare Part B. In 2006, the Centers for Medicare and Medicaid Services (CMS) interpreted the definition of ASP to include prompt pay discounts from manufacturers to wholesalers in the calculation of the payment to the physician, artificially lowering this reimbursement by 1.5% for drug purchases.

When the 1.5% prompt pay discount reduction is combined with other reductions in cancer drug reimbursement, including the 6-month lag in pricing data, and bad debt losses , reimbursement for many cancer drugs remains extremely low and even underwater for many cancer drugs. Ultimately these factors have a negative effect on cancer care practices and threaten access for cancer patients across the nation.

We urge you to make your voices heard on this critical issue. Take a few moments to make a phone call (talking points provided) or send an email (draft provided) to explain to your Members of Congress the seriousness of this disparity in Medicare reimbursement. Encourage them to cosponsor HR 905 (Whitfield/Green) and S 733 (Stabenow/Roberts) to ensure more appropriate payment for drugs and biologics under Medicare Part B.

Click here to contact your Representative to ask them to co-sponsor HR 905/S 733.

Click here for a handout on the prompt pay discount.

New Proposals for SGR Fix

Following House Ways and Means Republicans' request of approximately 70 medical societies for input on how to incorporate quality measures into a new Medicare physician payment formula, multiple groups have responded on how they believe quality, efficiency and outcomes should be addressed while reforming the way physicians are paid under Medicare.

Letters to the House Ways and Means Committee from the American Medical Association (AMA) and the Medical Group Management Association (MGMA) urged the repeal of the sustainable growth rate (SGR) formula and the provision of stable payments to doctors for several years while the Centers for Medicare and Medicaid Services (CMS) identifies a replacement payment mechanism. Additional recommendations from the groups include:

AMA:

- Remove administrative and regulatory barriers for physicians "who seek to engage in and lead innovative delivery models that promote quality, increase coordination, and reduce costs"
- Extend antitrust protections to providers that are pursuing innovative contracting arrangements with payers
- Ensure that physicians who are trying new models of care delivery are not prevented from having a meaningful market presence by hospitals and insurers who have achieved an anti-competitive, dominant market share
- Allow AMA's Physician Consortium for Performance Improvement to be involved in developing guidelines that physicians will have to follow and the outcomes they will have to meet
- Allow physicians to opt out of a certain number of electronic health record meaningful use requirements, and stop backdating penalties under the program

MGMA:

- Provide greater opportunity for physicians to experiment with new payment models for delivering and reimbursing care
- Offer timely data sharing and positive financial incentives to assist medical practices that want to experiment with alternative approaches to achieving savings
- Encourage greater flexibility within Medicare, and give physicians credit under Medicare Part B for savings they achieve in Part A
- Consider the reimbursement cuts to physicians now and in the near future under various quality reporting programs, including penalties under the electronic prescribing program, physician quality reporting program and electronic health record meaningful use program *(Continued on page 2)*

New Proposals for SGR Fix (cont'd)

- Stop backdating penalties under the electronic health record meaningful use requirements

Following the introduction of a bipartisan legislative proposal to permanently fix the SGR last week, Representatives Tom Price (R-GA) and Charles Boustany (R-LA) introduced another plan for replacing the SGR. Their proposal aims to motivate House Republicans to build consensus on a physician payment bill and directs the next Congress to develop a long-term solution for the payment cliff, estimated at approximately $300 billion. Components of the proposal include:

- Gainsharing to allow groups of providers work together to manage care and share savings through bonus payments.

- Balance billing to allow physicians to charge beneficiaries more than the Medicare payment rates. Although doctors already may charge up to 10 percent more than Medicare rates, only 0.5 percent of Medicare physicians do so.

- Medical malpractice reform offering liability protections for providers who adhere to accepted best practices.

Price and Boustany, both physicians and members of the House Ways and Means Committee, are working separately from the committee on their proposal.

Senate and House Pass User Fee Legislation

On May 24, the Senate passed the Drug Administration Safety and Innovation Act, intended to reauthorize prescription drug and medical device user fees, speed up prescription drug approval times, address U.S. prescription drug shortages and support patient access to innovative and life-saving devices and prescription medications.

The legislation passed by a vote of 96 to 1. If enacted into law, it will reauthorize prescription drug and medical device user fees that help fund new product reviews by the Food and Drug Administration (FDA) and will create new fees for the review of generic drugs. It will also establish new requirements for drug manufacturers to notify the government of potential shortages of anti-cancer drugs and other life-saving medications, and will mandate that federal officials take new steps to help mitigate or prevent the shortages.

On May 30, the House of Representatives approved a similar user fee bill by a vote of 387 to 5. House committee leaders prepared a revised version of the measure after the Congressional Budget Office (CBO) had estimated that it would add $247 million to the federal deficit over 10 years.

Now, an informal conference will commence between lawmakers in both chambers in order to work out differences in some areas, such as antibiotic incentives, generic drug pay-fors and medical device reforms. Leaders in both chambers have set a goal of passing a final bill that to be sent to President Obama by July 4.

Current prescription drug user fees are set to expire at the end of September, and the FDA has warned that if Congress delays reauthorization the agency may have to lay off as many as 2,000 staffers.

US Preventive Services Task Force Recommends Against Routine PSA Tests

On May 21, the U.S. Preventive Services Task Force issued a controversial final recommendation issuing a "D" grade for prostate-specific-antigen (PSA) testing to screen men for prostate cancer. Previously, the task force had recommended against routine PSA testing for men 75 and older. The latest recommendation applies to all ages and follows a similar draft recommendation issued in October.

In the task force's report, published online in the *Annals of Internal Medicine*, the panel noted that PSA testing detects many asymptomatic or slow-growing cancer cases that won't cause men any problems in their lifetimes, and the potential side effects from prostate cancer treatments outweigh the benefits. According to the task force website, a "D" grade means "there is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits."

(Continued on page 3)

US Preventive Services Task Force Recommends Against Routine PSA Tests *(cont'd)*

The task force reviewed clinical studies of PSA testing, including a large U.S. study that found no mortality benefit and a European study that suggested a modest benefit of no more than one in 1,000 men screened.

"You should know what the science says about PSA screening: There is a small potential benefit and there are significant potential harms," said the task force report. "But you should also think about your personal beliefs and preferences for health care."

The recommendation is not anticipated to affect Medicare coverage for the test, at least in the short term. In letters to members of Congress in February, Health and Human Services Secretary Kathleen Sebelius said that "while the department has discretion to modify or eliminate coverage for the PSA test based on the Task Force's recommendation, I do not intend to eliminate coverage of this screening test under Medicare at this time," and the Centers for Medicare and Medicaid Services (CMS) has said that Secretary Sebelius' statement stands following the USPSTF recommendation.

Private insurance plans will likely review their coverage decisions for the test, relying heavily on task force recommendations in coverage determinations.

Physicians' groups, lawmakers and others have spoken out in reaction to the final recommendation, saying that it may discourage primary care physicians from discussing prostate cancer screening with patients, particularly those at higher risk of developing it.

"It is inappropriate and irresponsible to issue a blanket statement against PSA testing, particularly for at-risk populations, such as African American men," said the American Urological Association. "Men who are in good health and have more than a 10-15 year life expectancy should have the choice to be tested and not discouraged from doing so."

Prostate cancer is the most common non-skin cancer diagnosed in men. The American Cancer Society estimates that 241,740 men will be diagnosed with prostate cancer this year and that 28,170 will die from it.