

Bad Medicine: Medicare's Part B Drug Payment Test

In March, the Centers for Medicare & Medicaid Services (CMS) announced its proposed Part B Drug Payment Demonstration – an initiative the cancer care community and patient advocates are deeply concerned will have negative consequences on the nearly 8.5 million Medicare beneficiaries with cancer, who depend on access to lifesaving treatments.

Risky Business for Cancer Patients

By focusing on costs, rather than patients and health care quality, CMS' test is nothing more than a risky gamble based on faulty assumptions – especially when it comes to patients who are battling cancer. Yet, the CMS initiative will put patients at tremendous risk, potentially forcing them to abandon treatments based upon zip codes, rather than trust their physician's judgment and understanding of their unique clinical characteristics and what treatments have been successful in fighting their cancer. The Part B Drug Payment Model would:

- Disproportionally impact cancer patients as approximately 50% of Part B drugs administered in the physician setting are cancer fighting agents, according to MedPAC;
- Hinder a provider's ability to prescribe the most appropriate cancer care treatment based strictly on the cost to purchase and maintain that drug;
- Create unnecessary barriers for providers to alter treatments when a patient's condition calls for it; and
- Force patients to seek care in hospitals or major medical centers – often at great inconvenience and increased personal expense.

CMS' Plan Does Not Acknowledge True Economics of Cancer Drug Reimbursement

Under the proposed payment model, Medicare will reduce payment for certain cancer drugs from the current ASP+6% payment methodology to ASP+2.5% with a flat fee of \$16.80 per drug per day administered. The reality is that the proposed payment cut is much deeper due to existing policies CMS has failed to account for in their proposal.

- The Budget Control Act of 2011 enacted a mandatory 2% sequester cut to Part B drugs in such a way that the actual payment set by Medicare in this model would be equivalent ASP+0.86%.
- The underlying formula by which ASP is derived currently includes a distributor prompt pay discount not realized by the provider.
- State taxes levied on prescription medicines, gross receipts and provider services disproportionately impact community-based practices. Further reductions will impede their ability to cover the acquisition cost of some cancer treatments.

“Medicare beneficiaries with life- threatening and/or disabling conditions would be forced to navigate a CMS initiative that could potentially lead to an abrupt halt in their treatment. This is not the right way to manage the Medicare program for its beneficiaries.”

- 316 patient and provider groups to House & Senate leaders

Lack of Evidence

Despite CMS' outlined goals, and its concern that the current 6% add-on to ASP may create incentives for use of higher priced drugs, there is no evidence that the proposed payment changes will improve quality of care or even reduce spending. In fact, data show otherwise.

- A recent study conducted by UnitedHealthcare showed that “eliminating existing financial chemotherapy drug incentives paradoxically increased the use of chemotherapy.” Drug spending increased by 179%.
- Data suggest that the current Part B drug payment system has been both cost effective and successful in ensuring patient access to their most appropriate treatment – Part B expenditures remain relatively stable and Part B drugs account for just 3% of total program costs.

Stakeholder Involvement Needed

The proposed demonstration project represents an alarming, excessive use of authority that lacks evidence and jeopardizes the health of our nation's most vulnerable cancer patients. A true demonstration project should be voluntary, small scale, centered on the quality and value of medical care provided to patients, and account for the unique needs of Medicare beneficiaries, through an open, deliberative process that involves all members of the affected communities – most importantly patients.

Too Much, Too Fast

Medicare program reforms, including several payment structure changes, are dramatically altering the reimbursement landscape for Medicare providers. The oncology community, in particular, is under stress as a result of various programs that will impact the delivery of care to cancer patients. While these reforms – such as the development of Alternative Payment Models (APM) under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and financial and performance accountability for the administration of chemotherapy drugs under the Oncology Care Model (OCM) – could result in positive outcomes including improved care coordination and reduced costs, that is yet to be seen.

Requiring cancer care providers to navigate through yet another payment reform experiment during a time of enormous change is too much at once. Instead, Medicare should examine how reforms already underway impact patient care – then look to additional reforms to improve the system.

CMS: Protect Patient Access to Cancer Care. Help Stop the Medicare Experiment.