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The US Oncology Network Chairman of the Pharmacy & Therapeutics Committee recently authored a column in *The Hill* newspaper in Washington, DC.

Dr. Brooks highlights the growing gap between reimbursements for cancer care provided in the community-based care setting and reimbursements for the same care provided in hospital outpatient departments. The Medicare Payment Advisory Commission (MedPAC) - the independent Congressional agency established to advise the U.S. Congress on issues affecting the Medicare program – has also identified payment discrepancies as an area for improvement. MedPAC recently recommended that reimbursement for healthcare services should be consistent, regardless of the setting in which those treatments take place.

Dr. Brooks writes, "Aligning payments for cancer care across settings – as MedPAC is recommending to Congress – simply makes sense. Not only is community-based care less expensive for Medicare – a typical one-hour IV chemotherapy infusion costs Medicare $133 in an office environment and $299 in the hospital outpatient department, but patients also prefer the community setting because it is typically closer to home and associated with shorter wait times."

Dr. Brooks also calls for passage of the Medicare Patient Access to Treatment Act, (H.R. 2869), a bill designed to equalize payments for cancer care across treatment settings. In addition to aligning Medicare payments for cancer care, the bill would provide beneficiary safeguards by protecting access to care in patient-preferred, community-based settings.

To contact your Member of Congress today and ask them to support the Medicare Patient Access to Treatment Act, click here.

OIG Releases Report on 340B Drug Discount Program

This month the Office of the Inspector General (OIG) released a report entitled "Contract Pharmacy Arrangements in the 340B Program," which examines the oversight, diversion, and methodologies for identifying 340B-eligible prescriptions.

The 340B Drug Discount Program is a federal program created to help uninsured patients gain greater access to prescription medicines. The program requires drug manufacturers to provide outpatient drugs to program participants – known as "covered entities" – at significantly reduced prices. The original intent of the program is to allow participating entities to reach more eligible patients and provide more comprehensive services.

The new OIG report finds inconsistencies in how 340B program covered entities determine if individuals are eligible for the program discounts. The report finds there are varying criteria for identifying which prescriptions are 340B-eligible. Among the hospitals examined in the IOG report, two-thirds do not offer the 340B price to uninsured patients.

Advocates are concerned that the poorest patients, for whom the program was created, are not benefiting from 340B drug discounts.

In response to the OIG report, the Alliance for Integrity and Reform of 340B (AIR 340B) – a coalition of patient advocacy groups, clinical care providers, and biopharmaceutical innovators – released a statement stating that the OIG report "provides further evidence that weak oversight and lack of regulatory clarity puts patient needs and care at risk, while in many cases hospitals use contract pharmacy arrangements to capture savings – real dollars – intended for needy patients."

The OIG report findings are a result of studies completed at 30 covered entities – 15 community health centers and 15 Disproportionate Share Hospitals (DSH) – and their contract pharmacies. In many cases, covered entities contract with pharmacies to dispense drugs purchased through the 340B program on the entity's behalf. Some of the entities studied did not offer uninsured patients the 340B rate for medications at any of their contract pharmacies, forcing patients to pay the full non-340B cost. Less than half of the entities studied reported offering the discounted 340B price to uninsured patients in at least one of their contract pharmacies.

The report further finds that covered entities reviewed by the IOG did not conduct all of the oversight activities by the Health Resources and Services Administration (HRSA), the government agency that oversees the program. HRSA has indicated plans to propose new regulations for the 340B program this year.

A bicameral group of Republican lawmakers quickly reacted to the OIG findings stating the report "indicates that there are insufficient safeguards in place to prevent illegal or wasteful use of taxpayer funds."

Congress Votes to Extend Sequestration Cuts

Both chambers of Congress have passed a bill extending sequestration by one year to 2024. The Congress voted to extend the sequestration cuts – which include a 2 percent across-the-board cut to Medicare payments – to pay for the reversal of a $6 billion reduction in military pensions.

The January budget deal cut the cost-of-living adjustment for veterans under the age of 62 by 1 percent. This policy was politically unpopular, forcing lawmakers to reverse their decision.

Several hospital groups, including the American Hospital Association sent a letter to lawmakers strongly opposing the sequester cuts extension.

Estimates predict the sequester extension will generate more savings than needed to pay for the restored veterans' benefits. The bill also establishes a transitional fund for extra savings to be used as part of a comprehensive overhaul of the Medicare physician payment system or for an extension of the current physician pay rates.

The legislation will now go to President Obama for his signature.

To read more on The US Oncology Network position on sequestration, click here.

Lancet Oncology Paper Calls on Oncology Community to Recognize Costs, Limitations of Cancer Treatments

On February 14, Lancet Oncology Journal released a paper entitled "Delivering maximum clinical benefit at an affordable price: engaging stakeholders in cancer care," urging the oncology community to take greater responsibility for its practice patterns, especially when using expensive tests and treatments with marginal value.

Paper authors Ronan J. Kelly, M.D. and Thomas J. Smith, M.D. of John Hopkins University cite data from the Journal of the National Cancer Institute, which projects cancer care spending in the U.S. will increase by more than 25 percent between 2010 and 2020, while equipment and product costs are also expected to increase by 39 percent.

Ronan and Smith stress that expensive costs in cancer care will put mounting pressure on the U.S. healthcare system in the years ahead, particularly as more aging Americans require healthcare services.

The paper highlights programs already in use that aim to reduce unnecessary spending and support appropriate use criteria, including the Choosing Wisely campaign.

The authors also discuss changes to the current reimbursement system for cancer care, suggesting the need for value-based pricing related to a treatment's effectiveness as well as expanded bargaining by the government to reduce drug prices.

This paper is the first in a series of three reports to be released by Lancet Oncology Journal on affordable cancer care.

To read a recent conversation with Dr. Thomas Smith, click here.

Insurance Exchange Enrollment Climbs to 3.3 Million

The U.S. Department of Health and Human Services (HHS) announced last week that enrollment through the state and federal insurance exchanges under the Affordable Care Act reached 3.3 million in January, which reflects a 53 percent increase in enrollment last month.

These latest HHS figures show 1.9 million enrollees through the federal HealthCare.gov website and 1.4 million through the state-run exchanges in 14 states and the District of Columbia.

HHS also reported that young adult enrollment outpaced other age groups. Last month alone, 27 percent of enrollees fell into the 18-34 age group.

The Administration is touting the momentum following the botched October 2013 rollout. HHS Secretary Sebelius framed the uptick in enrollment as "encouraging trends that more Americans are enrolling everyday, and finding quality, affordable coverage in the Marketplace."

Some experts warn that the HHS figures are not fully accurate because they do not report upon premium payments. While 3.3 million individuals have enrolled, there is no data available on how many of these individuals also made their first premium payments. If consumers enrolled in the marketplaces, yet failed to make premium payments, they do not currently have healthcare coverage.

The Congressional Budget Office (CBO) now projects 6 million enrollments by March 31, which is slightly down from CBO's original projection of 7.1 million enrollments by the end of March.

CBO Reports Slower Medicare Spending Growth

On February 4, the Congressional Budget Office (CBO) released its Budget and Economic Outlook: 2014-2024, which reports Medicare spending increased by only 2 percent in 2013. This signals the slowest rate of Medicare spending growth since 1999.

CBO also reports the Medicare beneficiary population is projected to grow from 51 million in 2013 to 71 million in 2024, which will accelerate Medicare spending by 6 percent per year over the next decade. Based on these projections, CBO estimates Medicare spending will reach $603 billion in 2014 and nearly $1.1 trillion in 2024.

By contrast, Medicaid spending grew by 6 percent in 2013 compared to 2012 levels, according to CBO's report. As more states expand their Medicaid populations under the healthcare reform law, Medicaid growth is expected to continue to accelerate. CBO estimates indicate that Medicaid program spending will increase by approximately 9 percent each year for the next 5 years.